

1
Item 18 Film 244 6-22-59 a.m.s
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

116730

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral parlor. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained by your files.
TO FUNERAL DIRECTOR: Page 4 should be used as a burial-transtional permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. STREET ADDRESS 18 East Sixth	
3. NAME OF DECEASED (Type or print) Michéal		First Michéal	Middle Wayne
4. DATE OF DEATH June 7 1959		Lost	Month June Doy 7 Year 1959
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 18, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Branison		14. MOTHER'S MAIDEN NAME Mary Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Branison 18 East 6th, Frederick		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 491X DUE TO Congestive Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO xxxxxxx Heart failure (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 1P		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O.Thomas		DATE SIGNED	
EXAMINER'S NAME (Type) B.O.Thomas, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 8, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-10-59	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS FAIRVIEW		22d. LOCATION (City, town, or county) Frederick - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES E. HICKS		24a. REC'D BY REGISTRAR DATE JUN 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

10:00 A.M.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG243 6-11-59 et

6741

CERTIFICATE OF DEATH

06731

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 16 13 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge	
d. STREET ADDRESS 06 X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lydia K		First	Middle
4. DATE OF DEATH June 3 1959		Last	Month
5. SEX Female	6. COLOR OF RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Smith		14. MOTHER'S MAIDEN NAME May Crawford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mary Willard		Address Union Bridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		Cerebral vascular accident (Cerebral Thrombosis) 2 wks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 1959, to June 3 , 1959, that I last saw the deceased alive on May 30 , 1959, and that death occurred at 4 3/4 M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6-3-59			
ACTUAL SIGNATURE Rex R. Martin		M.D. 95 E Church	
PHYSICIAN'S NAME (Type) Rex R. Martin		Frederick Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-6-59	
22c. NAME OF CEMETERY OR CREMATORIAL Blue Ridge Cemetery		22d. LOCATION (City, town, or county) Thurmont, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE JUN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

— 10 —

2000-01-00000000

新編 金華縣志

Wachstum und Zersetzung

卷一

237

0881-35

26

W. E. B. DuBois

2008 年

卷之三

THE BOSTONIAN 229

• <http://www.ams.org/proc-2012-110-0725-00000-00000>

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6742

CERTIFICATE OF DEATH

106732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401 Middle Alley		d. STREET ADDRESS 401 Middle Alley e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle - Brunner		4. DATE OF DEATH Month 6 Day 13 Year 1959	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-30-1910
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Winfield Scott		14. MOTHER'S MAIDEN NAME Martha Ann Timbers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Lola M. Hall, Baltimore, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Due to <i>myocardium infarct</i> Interval between onset and death 2 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>cardio vascular disease</i> 22 yrs +			
DUE TO (c) <i>loss of heart</i> 27 yrs +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 1955, to <i>June 13</i> , 1957, that I last saw the deceased alive on <i>June 12</i> , 1959, and that death occurred at <i>118</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>B. O. Thomas</i> M.D. ADDRESS (Street, city or town, state) <i>Frederick, Md.</i> DATE SIGNED <i>6/16/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-17-59	
22c. NAME OF CEMETERY OR CREMATORIAL Fair View		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. O. Thomas</i>		24a. REC'D BY REGISTRAR DATE JUN 18 '59	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knue</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 116733		
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick							
b. CITY OR TOWN (If outside corporate limits, write nearest town) Brunswick			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick			d. STREET ADDRESS 827 East "A"			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 827 East "A"					d. STREET ADDRESS 827 East "A"							
3. NAME OF DECEASED (Type or print)		First Daisy	Middle Alberta	Last Cornelius	4. DATE OF DEATH		Month 6	Day 30	Year 1959			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-1887		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Russell					14. MOTHER'S MAIDEN NAME Madora Wigington							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No			16. SOCIAL SECURITY NO.			17. INFORMANT Quinton R. Cornelius, Brunswick, Md.			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Atherosclerotic heart disease DUE TO (c) Generalized atherosclerosis										INTERVAL BETWEEN ONSET AND DEATH 5 yrs		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. 19 p. m.			20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Brunswick, Maryland		(County)	(State)	
21. I certify that I attended the deceased from 5-1-1959, to 6-30-1959, that I last saw the deceased alive on 6-30-1959, and that death occurred at 9:15 AM, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Brunswick, Maryland		
ACTUAL SIGNATURE C. E. Pruitt		DATE SIGNED 6-30-59										
PHYSICIAN'S NAME (Type) C. E. Pruitt		Brunswick, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-59		22c. NAME OF CEMETERY OR CREMATORIAL Park Heights			22d. LOCATION (City, town, or county) Brunswick, Maryland			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Pruitt		ADDRESS Brunswick, Maryland			24a. REC'D BY REGISTRAR DATE JUL 2 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kraus					
VS A15 (4) 15M 9/55												

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

16734

6743 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Frederick MARYLAND		Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS / 827 East "A"	
Memorial hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Lewis		H.	Cornelius
4. DATE OF DEATH		Month	Day
		June	24
		1959	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9/23/84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hostler		10b. KIND OF BUSINESS OR INDUSTRY B.&O. Shops	11. BIRTHPLACE (State or foreign country) West Virginia
			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James Cornelius		Annie Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mrs. Daisy Cornelius, Brunswick, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 34 hrs.	
331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral Hemorrhage	
(b) DUE TO		Hypertensive Vascular disease 5 yrs +	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/23, 1959, to 6/24, 1959, that I last saw the deceased alive on 6/24, 1959, and that death occurred at 4:45 PM, from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) Henry V. Chase M.D. 46 Church st 6/24/59 Henry V. Chase Frederick Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-27-59	
22c. NAME OF CEMETERY OR CREMATORIAL Park Heights		22d. LOCATION (City, town, or county) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Fife		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/53

INSTRUCTIONS

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326

327

328

329

330

331

332

333

334

335

336

337

338

339

340

341

342

343

344

345

346

347

348

349

350

351

352

353

354

355

356

357

358

359

360

361

362

363

364

365

366

367

368

369

370

371

372

373

374

375

376

377

378

379

380

381

382

383

384

385

386

387

388

389

390

391

392



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6744

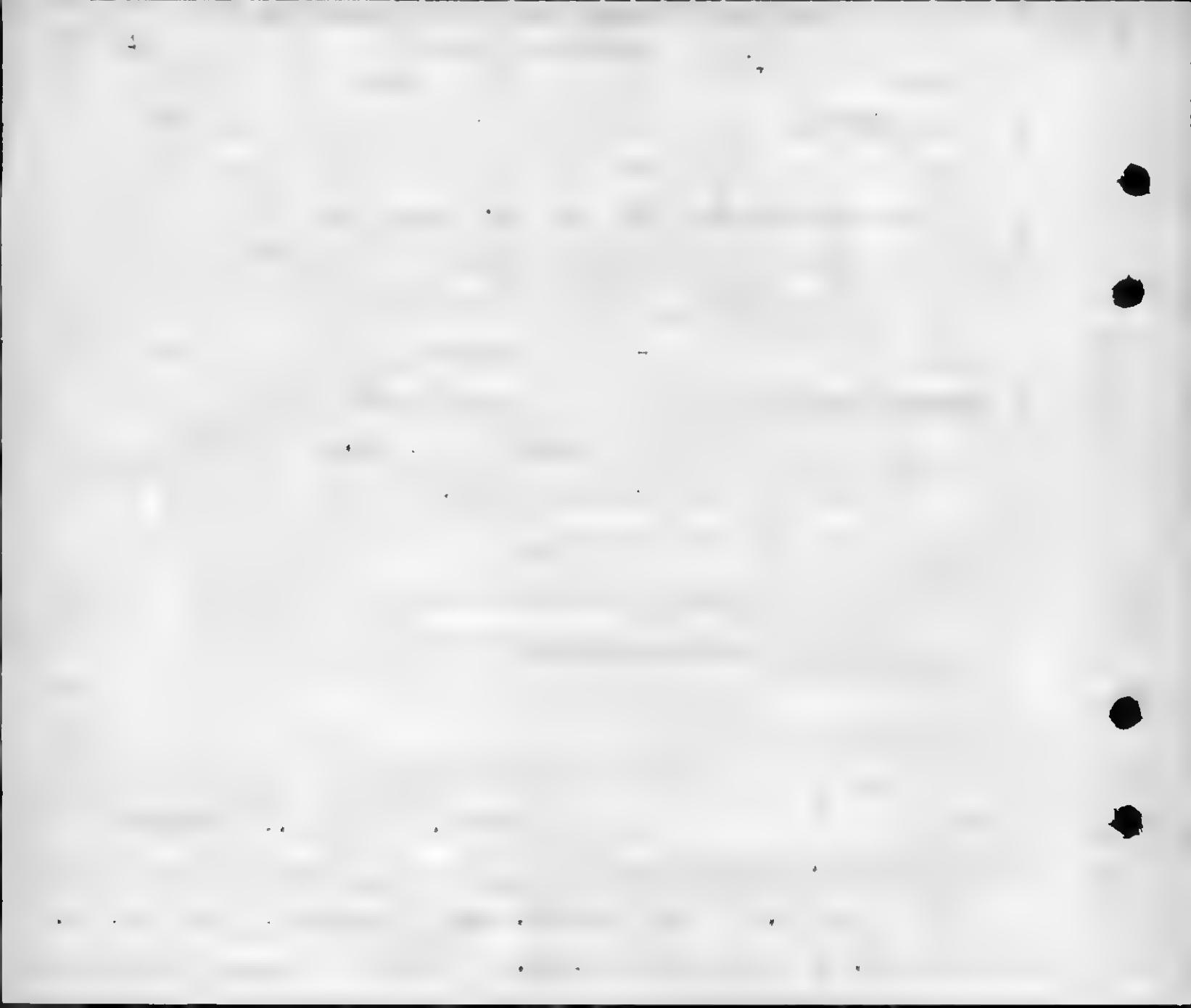
CERTIFICATE OF DEATH

06736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Rt. #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Terrance	Middle Lee	Last Eaton	4. DATE OF DEATH June 27	Month June	Day 27	Year 1959	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1959	9. AGE (In years last birthday) 1 yr.	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS Days 1	12. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Raymond Samuel Eaton				14. MOTHER'S MAIDEN NAME Annabel Mae Fisher				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mother		Address Rt. 3 Frederick		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atelectasis DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.	Month June	Day 27	Year 1959	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from <u>26 June 1959</u> to <u>27 June 1959</u> , that I last saw the deceased alive on <u>27 June 1959</u> , and that death occurred at <u>8:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) — DATE SIGNED ACTUAL SIGNATURE Fred J. Heldrich M.D. 220 N. Market St., Frederick								
PHYSICIAN'S NAME (Type) Fred J. Heldrich		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 29, 59		22c. NAME OF CEMETERY OR CREMATORIAL Frederick Mem. Park		22d. LOCATION (City, town, or county) Frederick, Frederick, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR C. H. & T. Inc.		24b. REGISTRAR'S SIGNATURE C. H. & T. Inc.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
Page 3 should be detached for the registrar prior to burial, cremation, or removal. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

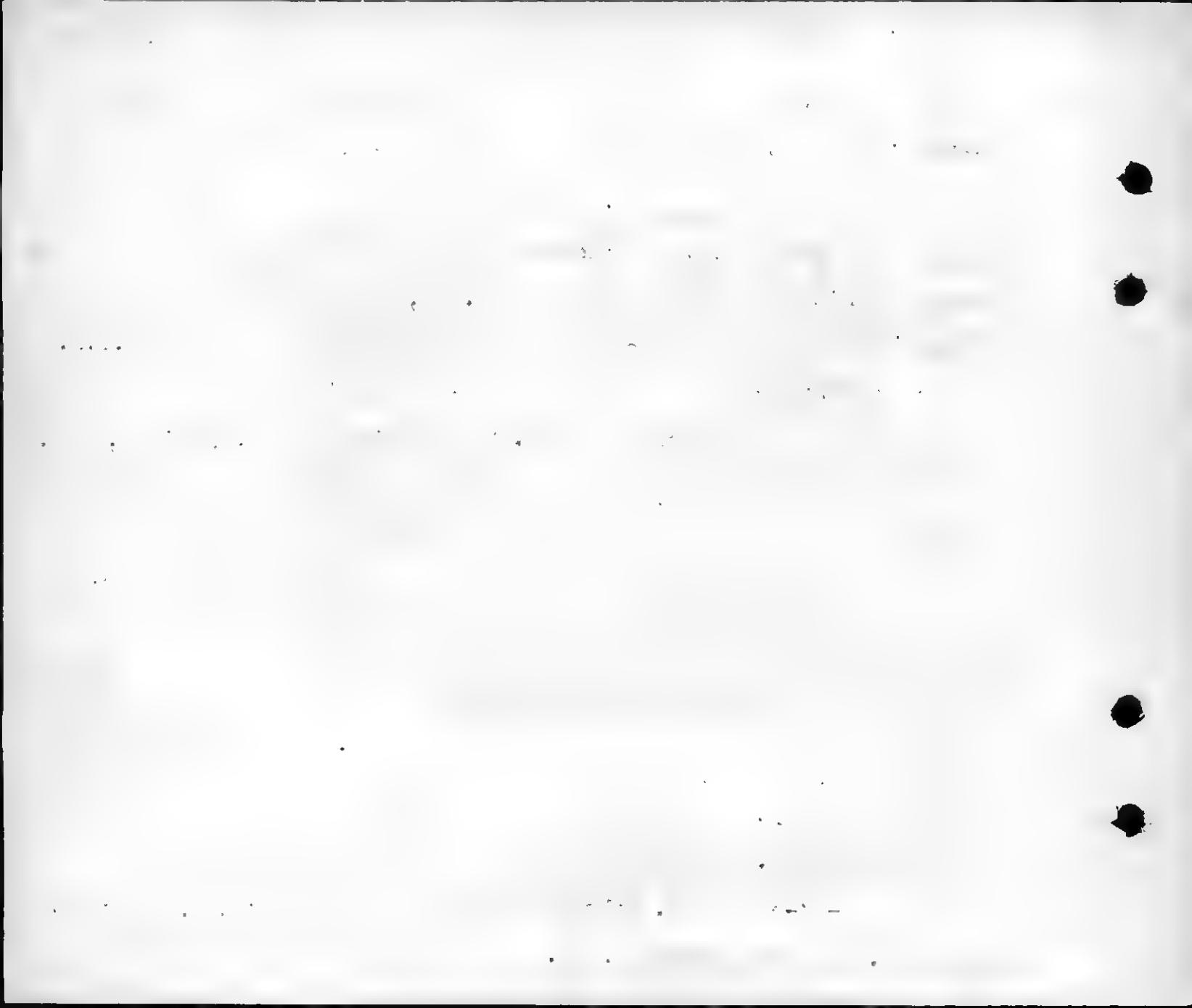
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

186737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give town)		c. LENGTH OF STAY IN lb 50 yr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rocky Ridge rural	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION		Rocky Ridge Md.—		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ellen	Middle Kate	Last Fleagle	4. DATE OF DEATH	Month June 15	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1867	9. AGE (in years last birthday) 91 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ephram Sharrer				14. MOTHER'S MAIDEN NAME Mary Stambaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Harry Knight		Address Rocky Ridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
493X <i>Pulmonary Edema Chronic</i> 1 mo							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <i>Myocardial Insufficiency</i> 1 mo							
DUE TO (c) <i>Chronic</i> 1 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)	(State)	
21. I certify that I attended the deceased from <u>5</u> , 19 <u>59</u> , to <u>6-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-25</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Thurmont, Md.</u> DATE SIGNED <u>Thomas A. Love</u>							
ACTUAL SIGNATURE <u>Thomas A. Love</u>		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-59	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Tabor Cemetery		22d. LOCATION (City, town, or county) Rocky Ridge, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager Thurmont, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 22 '59	24b. REGISTRAR'S SIGNATURE <u>Charles S. Thrane</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

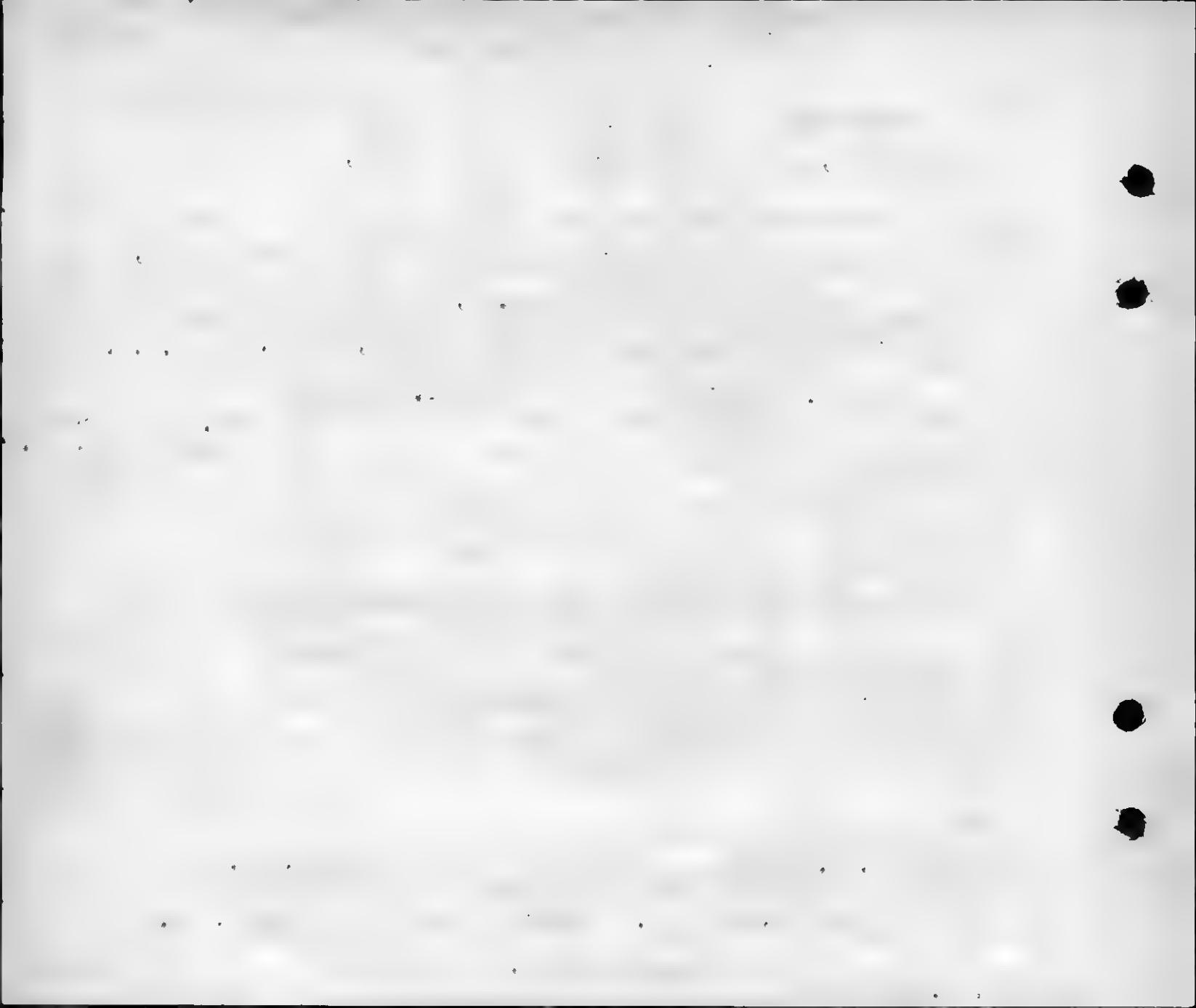
6771

CERTIFICATE OF DEATH

106738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,		b. COUNTY Frederick						
c. LENGTH OF STAY IN 1b 42 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Emmitsburg,						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION East Main Street		d. STREET ADDRESS East Main Street						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Mary	First Frances	Middle Gelwicks	Last 4. DATE OF DEATH June 9, 1959					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1890					
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS. Days 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Littlestown, Penna.					
12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME James D. Spalding		14. MOTHER'S MAIDEN NAME Mary A. Rider						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None						
17. INFORMANT <i>James D. Spalding</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Chronic ankylosing arthritis, severe (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. INTERVAL BETWEEN ONSET AND DEATH several years				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Emmitsburg, Md.	20f. (City or town) (County) Emmitsburg, Md.	(State) Md.
21. I certify that I attended the deceased from alive on June 9, 1959 , and that death occurred at Emmitsburg, Md. , from the causes and on the date stated above. ACTUAL SIGNATURE W. R. Cadle		ADDRESS (Street, city or town, state) Emmitsburg, Md.		DATE SIGNED 6-9-59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 11, 1959		22c. NAME OF CEMETERY OR CREMATORIUM St. Joseph's Catholic		22d. LOCATION (City, town, or county) Emmitsburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR Arthur S. Kline		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		
VII A15 (4) 15M 9/55				DATE JUN 11 '59				
C. E. Wilson								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6745

CERTIFICATE OF DEATH

06739

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick MARYLAND		a. STATE Md b. COUNTY Fred.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Frederick		DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick Memorial Hosp		Frederick 425 Kline Harts	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
George William Gordon		Month 6	Day 13
5. S. SEX M		6. COLOR OR RACE 6C	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH MAR 1-1921 38 yrs	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
GENERAL - Maintenance-Store		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME John Gordon		12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME Mary Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? yes	
16. SOCIAL SECURITY NO. W.W. T 215-18-2906		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		3 days	
DUE TO Lobar pneumonia		10 yrs or more	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause last.</u>		Chronic Alcoholism	
DUE TO (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 11, 1959, to June 13, 1959, that I last saw the deceased alive on June 13, 1959, and that death occurred at 5:54 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Ralph L. Michaels		M.D. Shopping Center, Frederick, Maryland	
PHYSICIAN'S NAME (Type)		22a. BUR. AL. CREMATION, REMOVAL (Specify) BURIAL 6-16-59 FAIRVIEW	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
22d. LOCATION (City, town, or county) Frederick Md. (State)		22d. LOCATION (City, town, or county) Frederick Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks		24a. REC'D BY REGISTRAR DATE JUN 16 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur & Anna	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6772

CERTIFICATE OF DEATH

06740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7		c. LENGTH OF STAY IN 1b 59 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#4					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital				d. STREET ADDRESS Feagaville		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BERTHA		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 18 June 1885	9. AGE (In years less birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Unglebower					14. MOTHER'S MAIDEN NAME Josephine Stockman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) NO					16. SOCIAL SECURITY NO 216-22-9827				
17. INFORMANT William H. Gross (Same as item #2)					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42d.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Altered Sclerosis (c)					INTERVAL BETWEEN ONSET AND DEATH 54 hr.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Endysis Apathies					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from <u>Apr 25</u> , 1947 to <u>June 20</u> , 1959, that I last saw the deceased alive on <u>June 20</u> , 1959, and that death occurred at <u>4:35 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>H. F. Kline</u>		ADDRESS (Street, city or town, state) <u>7 N. Market St.</u> DATE SIGNED <u>24 June 1959</u>							
PHYSICIAN'S NAME (Type) H. F. Kline, M. D.		Frederick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-59		22c. NAME OF CEMETERY OR CREMATORIUM St. Luke's Cemetery		22d. LOCATION (City, town, or county) Feagaville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS M. R. Etchison & Son, Frederick, Maryland							
24a. REC'D BY REGISTRAR DATE JUN 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6745 CERTIFICATE OF DEATH

Reg. Dist. No. **116741**

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 West Seventh Street			d. STREET ADDRESS 8 West Seventh Street		
3. NAME OF DECEASED (Type or print) DAISY ERMA HAGAN			4. DATE OF DEATH Month June Day 19 , Year 1959		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 4 Aug 1875	9. AGE (In years last birthday) 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Frederick, Maryland	
13. FATHER'S NAME William T. Beall			14. MOTHER'S MAIDEN NAME Flora Newmyer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Charles C. Brust (Same as item #1)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 47 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1 , 19 57 , to 6-18 , 19 59 , that I last saw the deceased alive on 6-18 , 19 59 , and that death occurred at 6:45A M, from the causes and on the date stated above. ACTUAL SIGNATURE U. G. Bourne, Jr., M. D. ADDRESS (Street, city or town, state) 30 W. All Saints St. DATE SIGNED 6-19-1959					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-59	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.			ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 23 '59	24b. REGISTRAR'S SIGNATURE Arthur & Thorne



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6773

CERTIFICATE OF DEATH

116742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodstock</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Woodstock</i>	
3. NAME OF DECEASED (Type or print) <i>ROGER FROCK HAHN</i>		4. DATE OF DEATH <i>June 4 1959</i>	Month Day Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 18, 1917</i>
9. AGE (In years lost birthday) <i>42 yrs.</i>		10. IF UNDER 1 YEAR Months <i>4</i>	11. IF UNDER 24 HRS Days <i>0</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Clarence W. Hahn</i>	
14. MOTHER'S MAIDEN NAME <i>L. Ruth Frock</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>214-16-0354</i>		17. INFORMANT Address <i>Mrs Roger Hahn, Woodstock, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Arteriosclerotic CVD</i> (c)		10 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>16 May</i> , 1959 to <i>4 June</i> , 1959, that I last saw the deceased alive on <i>4 June</i> , 1959, and that death occurred at <i>5 p.m.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James S. Stone Jr.</i> M.D. ADDRESS (Street, city or town, state) <i>Walkersville, Md</i> DATE SIGNED <i>5 June 1959</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 7, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Rocky Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>in Woodstock Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton</i>		24a. ADDRESS <i>Walkersville, Md.</i>	
24b. REC'D BY REGISTRAR DATE <i>JUN 8 '59</i>		24c. REGISTRAR'S SIGNATURE <i>Orlina S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



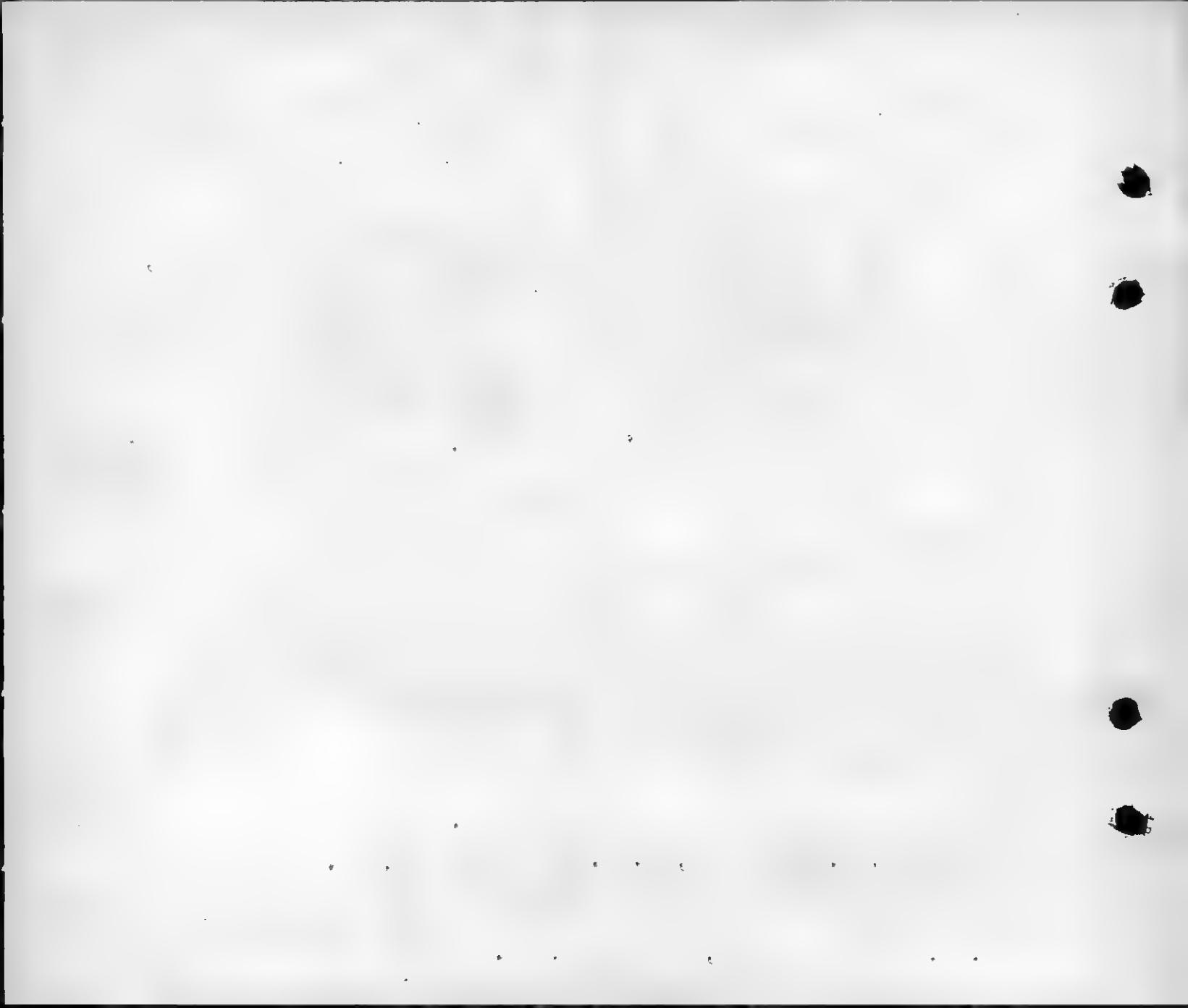
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6766

116743

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b 8 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 210 Seventh Avenue			d. STREET ADDRESS 210 Seventh Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) NELLIE		First MASON	Middle HARWOOD	Last HARWOOD	4. DATE OF DEATH June 19, 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 13 Jan 1878	9. AGE (In years last birthday) 81 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George Newkirk			14. MOTHER'S MAIDEN NAME Mary Anderson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT George T. Harwood (Same as item #1)	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis					
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)					
DUE TO					
C. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13, 1959 to June 19, 1959 that I last saw the deceased alive on June 19, 1959 and that death occurred at 8:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 S. Maryland Ave DATE SIGNED June 20, 1959					
ACTUAL SIGNATURE 					
PHYSICIAN'S NAME (Type) C. T. Byron Kao, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 23, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick, Maryland				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.					
ADDRESS			24a. REC'D BY REGISTRAR DATE JUN 23 '59		
			24b. REGISTRAR'S SIGNATURE Arthur & Krause		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6774

CERTIFICATE OF DEATH

116744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Broadneck Heights</i>		c. LENGTH OF STAY IN 1b <i>12 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Braddock Heights</i>		d. STREET ADDRESS (Correct) <i>Jefferson Boulevard</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Vindobona Inc.</i>				d. STREET ADDRESS (Correct) <i>Jefferson Boulevard</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Harry</i>		First <i>H</i>	Middle <i>L</i>	Last <i>Hoffman</i>	4. DATE OF DEATH Month <i>June</i>	Day <i>29</i>	Year <i>1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3 Oct 1873</i>	9. AGE (In years from birthday) <i>85</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Almanager</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dry Cleaning</i>		11. BIRTHPLACE (State or foreign country) <i>Unk</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unk</i>				14. MOTHER'S MAIDEN NAME <i>Unk</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Unk</i>		17. INFORMANT <i>Vindobona, Inc., (Same as item #1)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Stomach</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pyelonephritis</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>ADDRESS (Street, city or town, state)</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>228 N Market St Frederick</i>		20f. (City or town) (County) (State) <i>Frederick, Md.</i>	
21. I certify that I attended the deceased from <i>5/22</i> , 19 <i>59</i> , to <i>6/29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6/28</i> , 19 <i>59</i> , and that death occurred at <i>8:30 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>L. R. Schoolman</i> M.D. ADDRESS (Street, city or town, state) <i>228 N Market St Frederick</i> DATE SIGNED <i>6/28/59</i>							
PHYSICIAN'S NAME (Type) <i>L. R. Schoolman, M. D.</i>		Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>6-30-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Philadelphia, Pa.</i>		22d. LOCATION (City, town, or county) (State) <i>Philadelphia, Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison & Son, Frederick, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 2 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6747

CERTIFICATE OF DEATH

116745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
3. NAME OF DECEASED (Type or print) Elizabeth E. Holland		d. STREET ADDRESS 15 West "I"	
4. DATE OF DEATH June 11 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-15-1894
9. AGE (In years 65 (birthday) yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Un known		14. MOTHER'S MAIDEN NAME Un known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Donald Holland, Knoxville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hyperensive Cardiovascular disease (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/9, 1959, to 6/11, 1959, that I last saw the deceased alive on 6/10, 1959, and that death occurred at 9 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Henry V. Chase M.D.		ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 6/11/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-15-1959	22c. NAME OF CEMETERY OR CREMATORIUM St. Marys
22d. LOCATION (City, town, or county) Petersville, Maryland		24a. REC'D BY REGISTRAR DATE JUN 16 '59	
23. FUNERAL DIRECTOR'S SIGNATURE John Geets		24b. REGISTRAR'S SIGNATURE Colvin S. Kraus	
ADDRESS Brunswick, Maryland			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

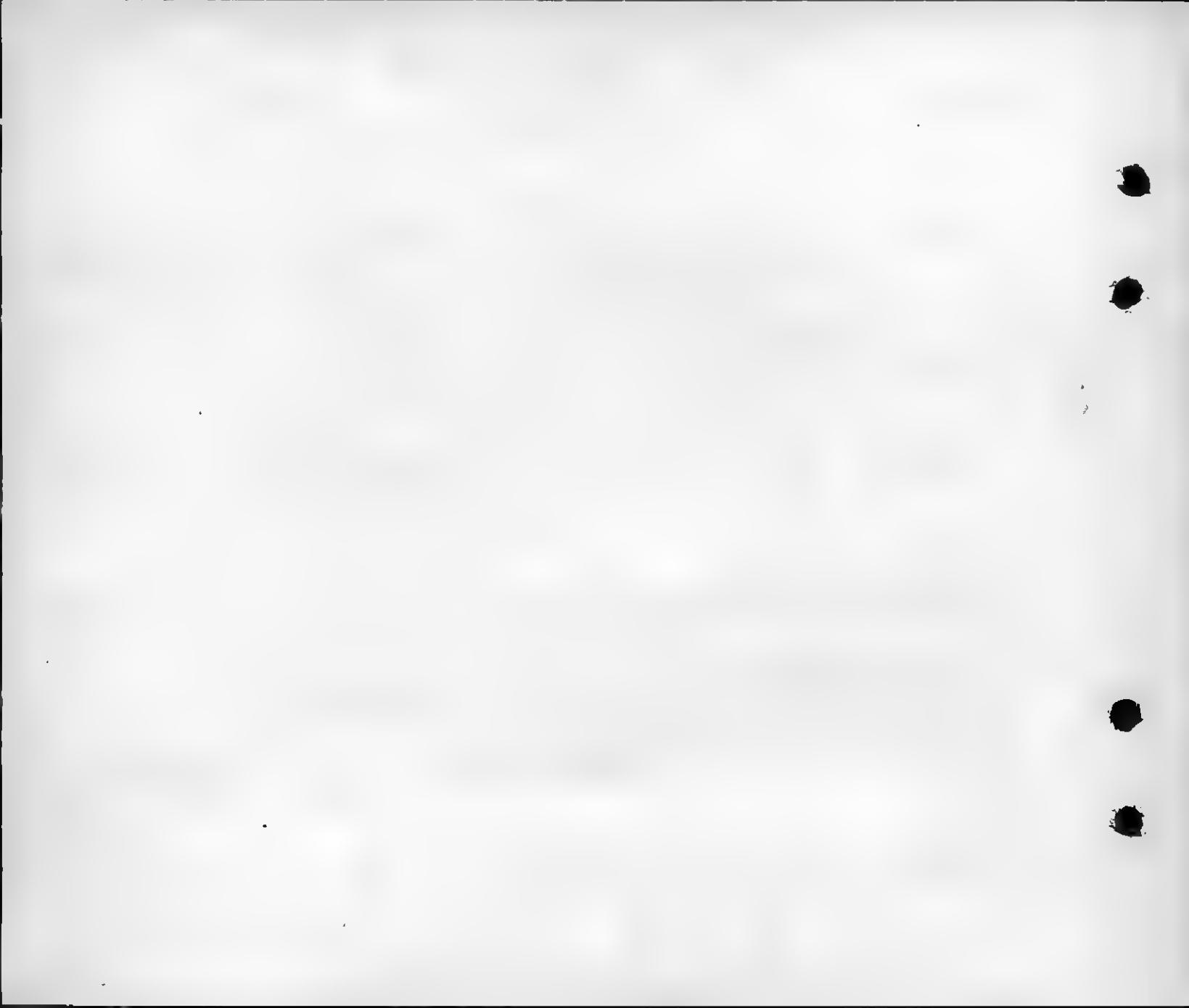
6748

CERTIFICATE OF DEATH

06746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK CITY		c. LENGTH OF STAY IN lb EIGHT DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		e. STREET ADDRESS MIDDLETOWN MD. R-1		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ALVERDA JANE HOLMES		First	Middle	Last	4. DATE OF DEATH JUNE - 21 - 1959	Month	Day	Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 14. 1876	9. AGE (In years last birthday) 82 yrs	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS Days 7	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) SHARPSBURG WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME JOHN SNYDER		14. MOTHER'S MAIDEN NAME ELIZA		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. ETHEL PAYNE MIDDLETOWN MD. R-1
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure		DUE TO Arteriosclerosis, general		INTERVAL BETWEEN ONSET AND DEATH 2-3 mos				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last Angina		DUE TO Carcinoma of nasal septum		INTERVAL BETWEEN ONSET AND DEATH unknown				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Middletown, Md.		20f. (City or town) Middletown	(County) Middle	(State) Md.
21. I certify that I attended the deceased from June 2, 1959 to June 21, 1959 , that I last saw the deceased alive on June 20, 1959 and that death occurred after 6 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Middletown, Md.		DATE SIGNED 6/23/59				
ACTUAL SIGNATURE <i>Kenneth C. Henson</i>		PHYSICIAN'S NAME (Type) Kenneth C. Henson						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 24, 1959		22c. NAME OF CEMETERY OR CREMATORIUM SAMPLES MANOR CEMETERY		22d. LOCATION (City, town, or county) Middle		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>John C. Ball</i>		ADDRESS Boonsboro MD		24a. REC'D BY REGISTRAR DATE JUN 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Lewis		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6749

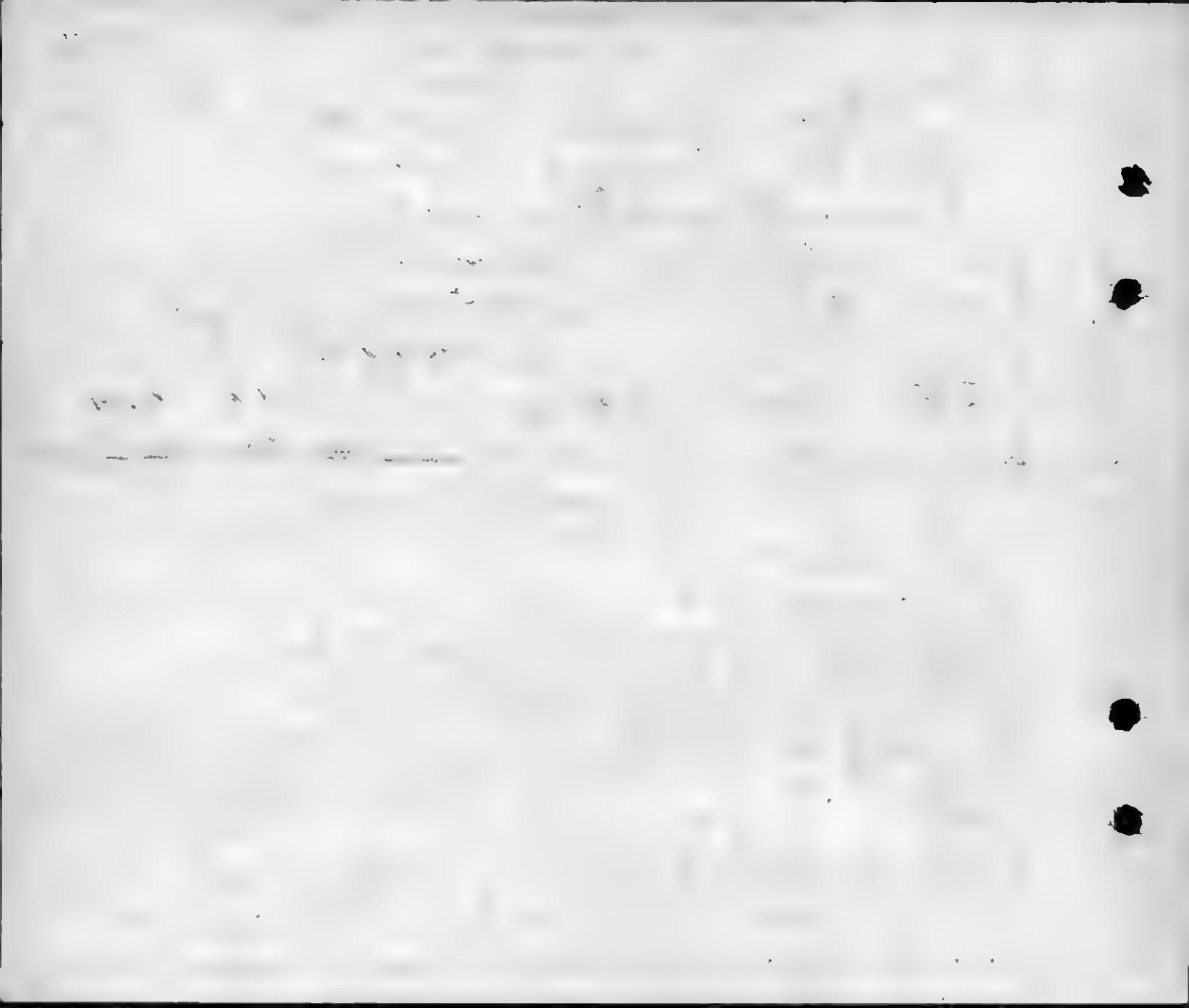
CERTIFICATE OF DEATH

Reg. Dist. No.

05603

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived / If institution: Residence before admission) a. STATE	
Frederick MARYLAND		Maryland Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN Tb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick	1b	D.C. Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Frederick Memorial Hosp		402 Thomas Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Initials
Michael	Phay	Hysong	
4. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Male	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5/30/59
9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Day
6	2	3	Year 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Infant		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		meyland	
13. FATHER'S NAME		14. MOTHER'S MATURE NAME	
John Bolland Hysong		Shirley Edna May	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT		Address	
Mother		402 Thomas Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>			
768.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.			
(b) <u>Acute virunis-myocarditis</u>			
DUE TO			
(c)			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Moer o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/30</u> , 19 <u>59</u> , to <u>6/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/2</u> , 19 <u>59</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		Lutheran Cemetery	
22d. LOCATION (City, town, or county)		(State)	
Middletown,		Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
M. R. Etchison & Son, Frederick, Maryland		24b. REGISTRAR'S SIGNATURE	
Signature		Signature	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6775

CERTIFICATE OF DEATH

116747

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 27 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown - RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home - RURAL - Rt. 4		d. STREET ADDRESS Buckeystown - Rt. 4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sophia	First Whalen	Middle Lawson	Last Jackson
4. DATE OF DEATH 6 24 19 59	Month 6	Day 24	Year 19 59
5. SEX Female	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/90
9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (domestic)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Point of Rocks, Md	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME William Whalen	14. MOTHER'S MAIDEN NAME Ida Bowins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 219-078-239	INFORMANT Oscar Baltimore Jackson	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0			
DUE TO Obstructive heart failure, acute			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease			
DUE TO (c) Month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/17 19 59 to 6/24 19 59 , that I last saw the deceased alive on 6/22 19 59 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James B. Thomas</i>		ADDRESS (Street, city or town, state) M.D.	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION REMOVAL Burial	22b. DATE THEREOF 6-28-59	22c. NAME OF CEMETERY OR CREMATORIAL Point of Rocks	22d. LOCATION (City, town, or county) Frederick - Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks # Fred. Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas



13
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2.57

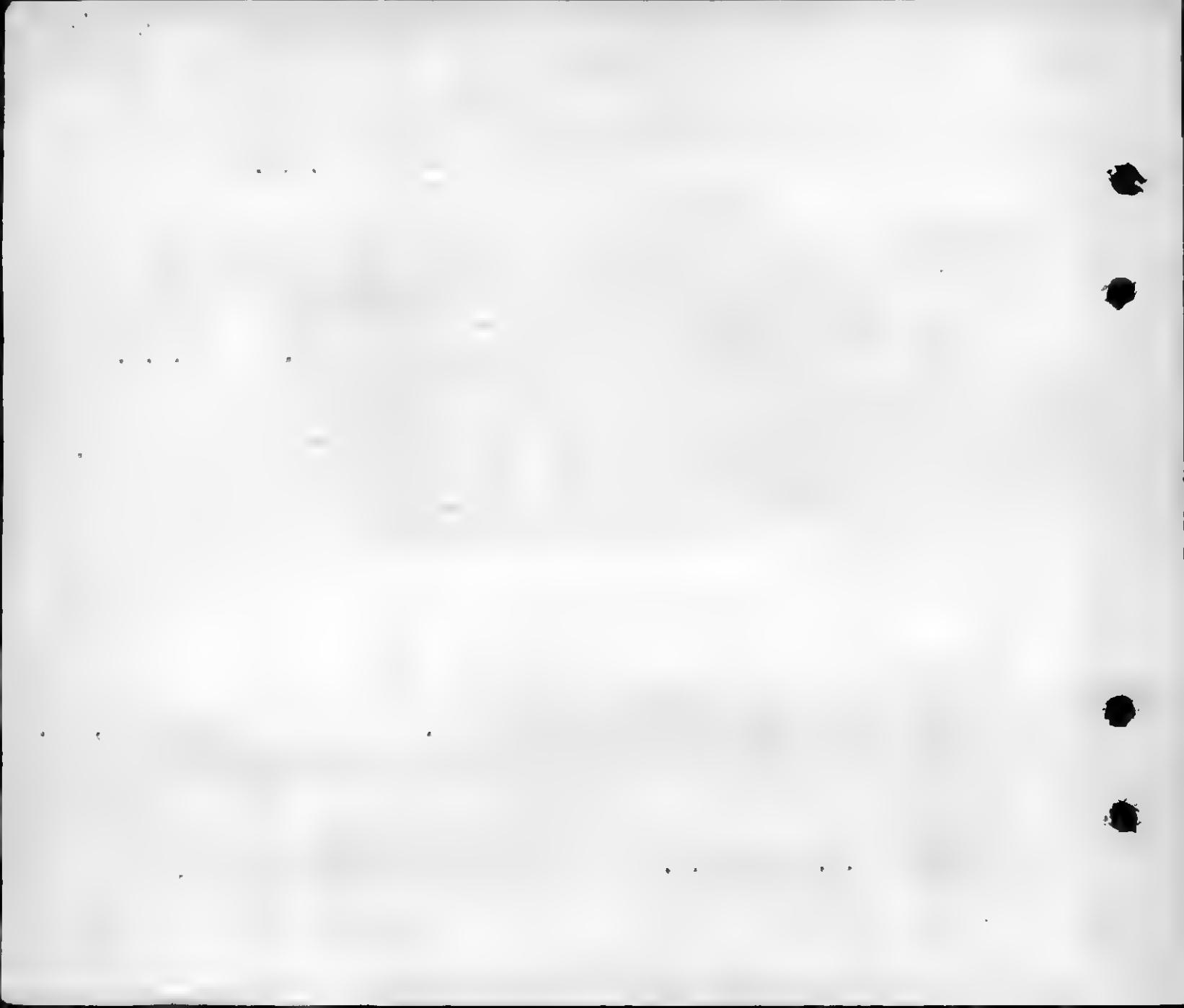
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

106748

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 16 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ALLEY ON STREET		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Kloman		First Klenwood	Middle Jones
4. DATE OF DEATH June 27, 1959		5. SEX Male	6. COLOR OR RACE Colored
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH MAR 15 1940	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY BY MONTH	
11. BIRTHPLACE (State or foreign country) Frederick Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Rosie Willis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 213-28-7621	
17. INFORMANT		Address William Jones, New Windsor R.F.D.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Bullet passed thru left lung Heart & lacerated rt lung. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot in left chest	
20c. TIME OF INJURY 12-05 June 27, 1959		20d. INJURY OCCURRED Month, Day, Year White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Allegany St		20f. (City or town) Frederick, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED June 29, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6/3, 1959		22b. DATE THEREOF 6/3, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL MT. JOY		22d. LOCATION (City, town, or county) UNION TOWNSHIP	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Hargan & Sons Funeral Directors		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

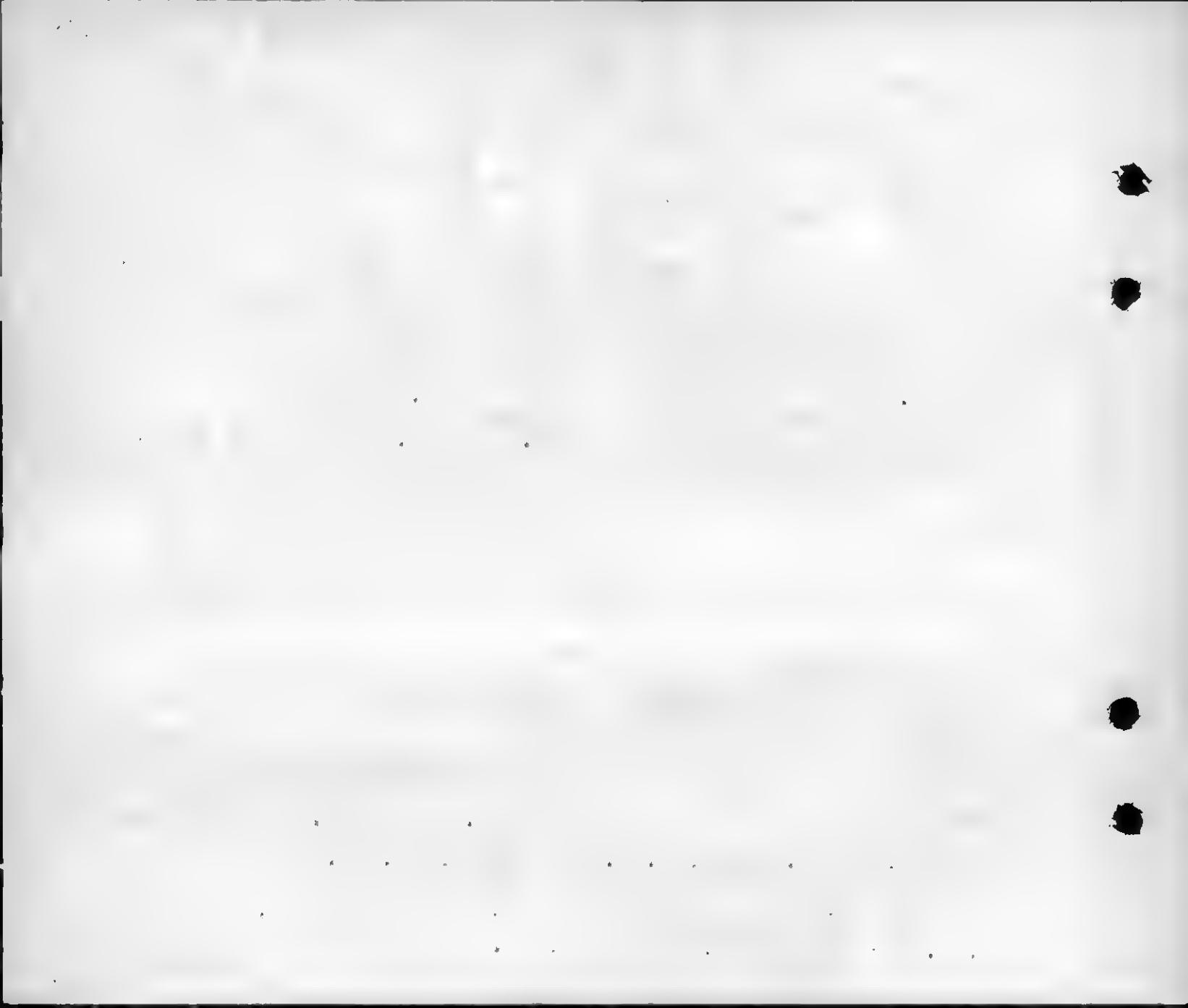


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 116749

6750 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FLORA	Middle MAE	Last KELLER	4. DATE OF DEATH	Month June Doy 19 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5 Oct 1881	9. AGE (In years lost birthday) 77 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Olin W. Rice			14. MOTHER'S MAIDEN NAME Emma E. Rice		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Belva K. Ayers (Same as item #2)	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Multiple Myeloma</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/11/59 , 19, to 6/19 , 1959, that I last saw the deceased alive on 6/19 , 1959, and that death occurred at 12:45 P.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) 4 E. Church St. DATE SIGNED 20 June 1959					
ACTUAL SIGNATURE <i>Henry V. Chase</i>		PHYSICIAN'S NAME (Type) Henry V. Chase, M. D. Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-59		22c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery	
22d. LOCATION (City, town, or county) Jefferson, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 23 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

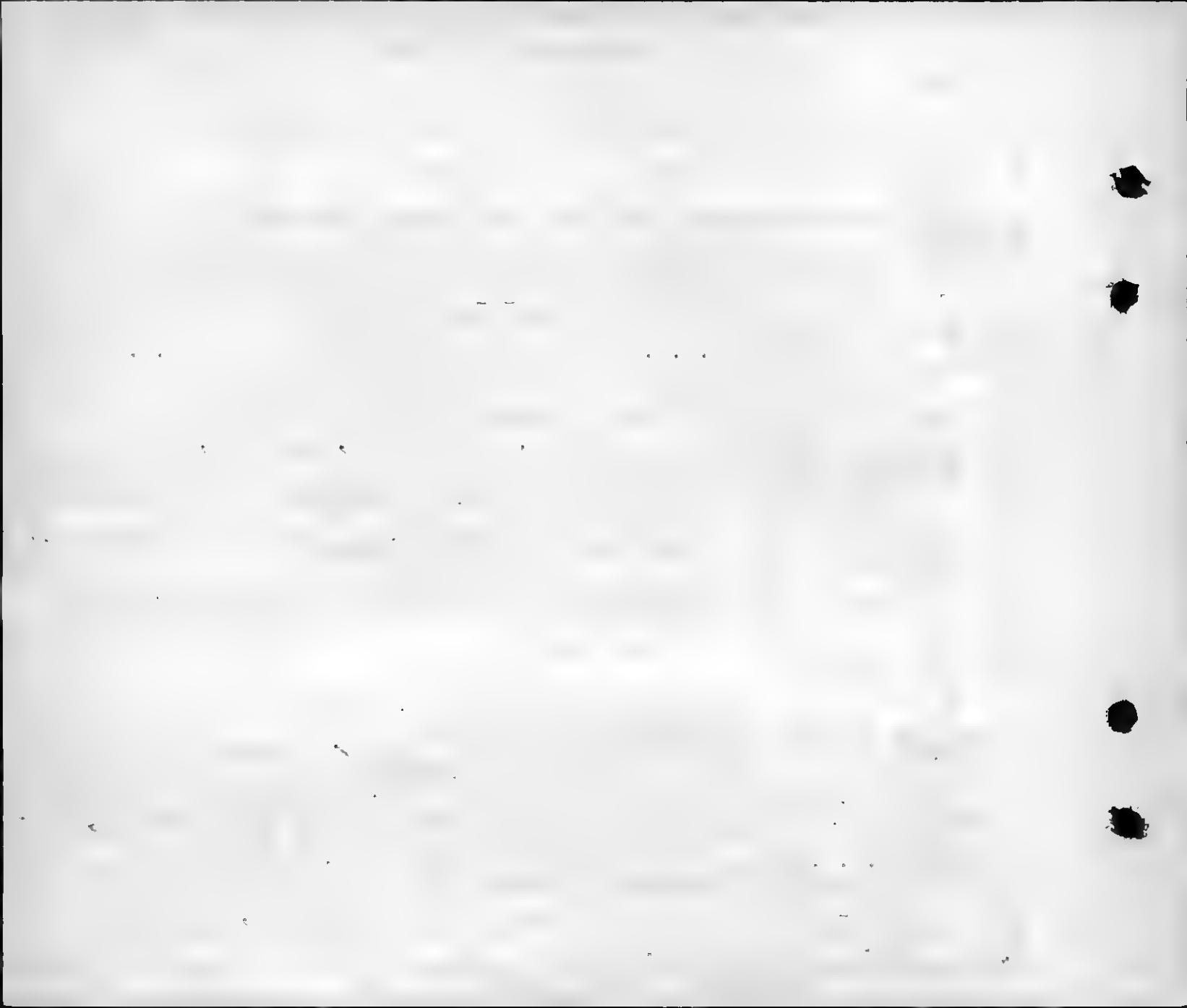
116750

6767

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 311 Brunswick Street		d. STREET ADDRESS 311 Brunswick Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Grove	Last Kidwell
4. DATE OF DEATH	Month 6	Day 10	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH 7-4-1889		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Forman)		10b. KIND OF BUSINESS OR INDUSTRY B.&O. Shops	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilfred Kidwell		14. MOTHER'S MAIDEN NAME Martha Sigafoose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 17. INFORMANT Mrs. Ida Kidwell, Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH acute 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 1958</u> to <u>Oct. 1959</u> , that I last saw the deceased alive on <u>6/15/59</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) J.G.F. Smith		ADDRESS (Street, city or town, state) M.D. <u>Dr. James W. Kidwell</u> Brunswick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-13-1959	22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Lee Gute</u>	ADDRESS Brunswick, Maryland	24a. REC'D BY REGISTRAR DATE JUN 15 '59	24b. REGISTRAR'S SIGNATURE Arline S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6751

CERTIFICATE OF DEATH

116751

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be placed in the burial permit. Then please remove carbon paper, pages 1 and 2, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRED		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovestown		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Richard H King		First	Middle	Last	4. DATE OF DEATH June 28 1954	Month	Day	Year	
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5-26-37	9. AGE (In years last birthday) yrs. 27	IF UNDER 1 YEAR Months 226	IF UNDER 24 HRS. Days 226	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Woodrow W. King		14. MOTHER'S MOTHER'S NAME Margaret Hest		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Irreversible shock				INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last.		(b) DUE TO Dehydration				?			
(c) DUE TO Gastroenteritis						?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) (County) Frederick		(State)	
21. I certify that I attended the deceased from 26 June 1954 to 28 June 1954 that I last saw the deceased alive on 28 June 1954 , and that death occurred at 11 P.M. M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 11 Market St Frederick MD			
ACTUAL SIGNATURE J. A. HELDRICK						DATE SIGNED 6-30-54			
PHYSICIAN'S NAME (Type) J. A. HELDRICK									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 30-54 Lovestown Cemetery		22b. DATE THEREOF June 30-54		22c. NAME OF CEMETERY OR CREMATORIAL Lovestown Cemetery		22d. LOCATION (City, town, or county) Lovestown MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond B. Bryan Thurmont		ADDRESS 120 Main St Thurmont		24a. REC'D BY REGISTRAR DATE JUL 2 '59		24b. REGISTRAR'S SIGNATURE Arthur & Anna			

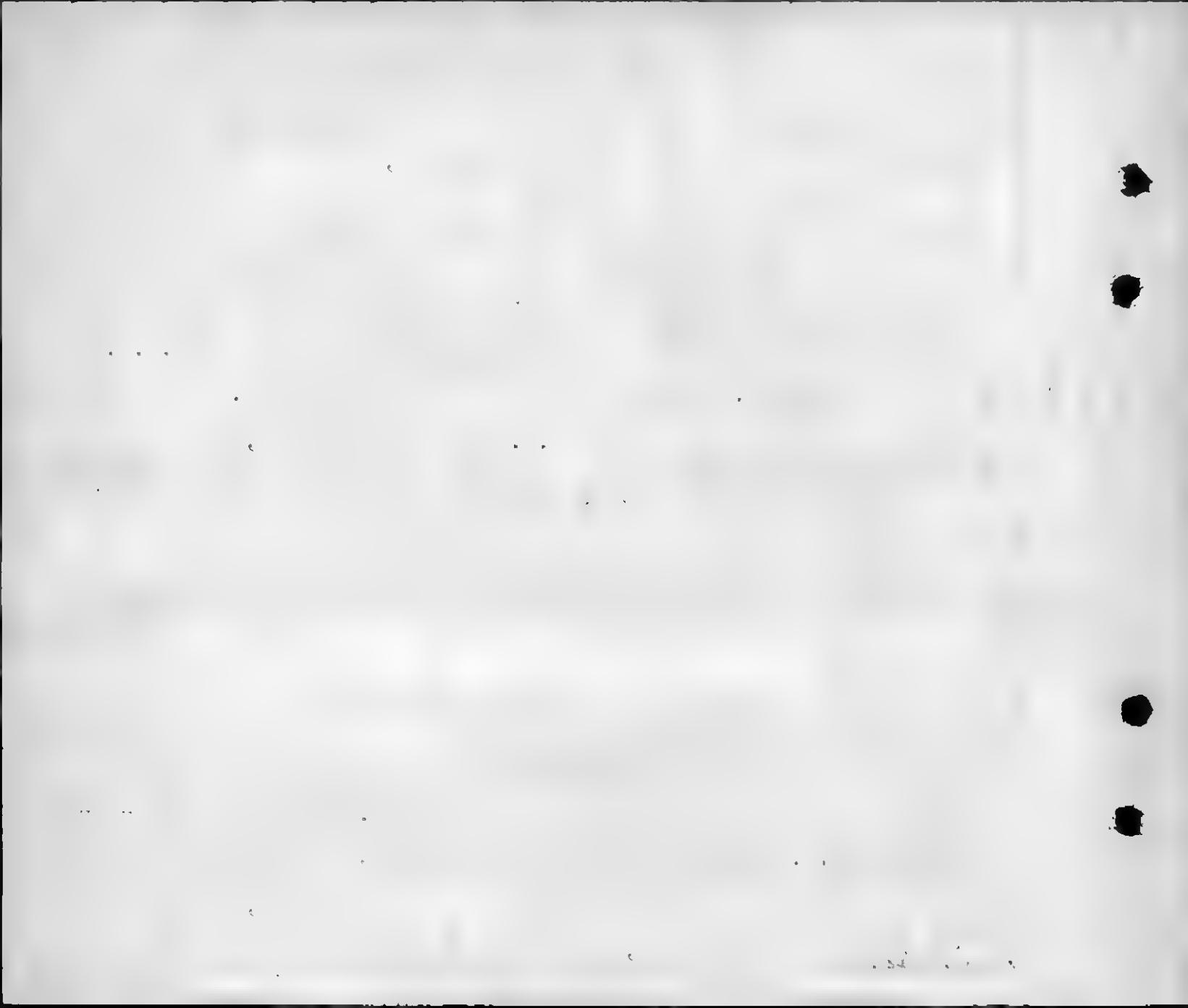


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6768 CERTIFICATE OF DEATH

116752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Frederick MARYLAND		Maryland Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 East "C" M		d. STREET ADDRESS 20 East "C" M	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lola Amelia Kline		4. DATE OF DEATH 6 29 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8-29 1891	
9. AGE (In years lost, birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George O. Barger		14. MOTHER'S MAIDEN NAME Altie A. McBride	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. W.M. Kline	
17. INFORMANT W.M. Kline		Address Brunswick, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. INTERVAL BETWEEN ONSET AND DEATH 9 days	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause first.		Dr. B. M. Kline - RT Died of Diabetes mellitus vs you.	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-25-1959 to 6-29-1959, that I last saw the deceased alive on 6-29-1959, and that death occurred at 12 NOON from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Brunswick, Maryland DATE SIGNED 6-29-59	
ACTUAL SIGNATURE C. E. Pruitt		M.D.	
PHYSICIAN'S NAME (Type)		Brunswick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-59	
22c. NAME OF CEMETERY OR CREMATORIAL Park Heights		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. M. Kline		24a. REC'D BY REGISTRAR DATE JUL 2 '59	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6777

CERTIFICATE OF DEATH

116753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick MARYLAND		a. STATE MARYLAND Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Frederick	
RURAL Middletown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
valley View NURSING Home		Route ?	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Alice	Middle Virginia
4. DATE OF DEATH		Month June	Day 29
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Female		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (in years last birthday) 68 yrs.	
6-23-1891		IF UNDER 1 YEAR	IF UNDER 24 HRS
		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Leather Worker		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Kipp		Ila F. Hart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
NO		17. INFORMANT	
		215-204143 Miss Margaret S. Kipp	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address RT. 7-Frederick	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 mos	
422.1		Myocardial Insufficiency	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Cystic Sclerosis (Generalized)	
DUE TO		(c) Hyperthyroidism	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY		Month, Day, Year	
Hour a. m. 19		20d. INJURY OCCURRED	
p. m.		White	Not while
		at work	at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	
		(County)	
		(State)	
21. I certify that I attended the deceased from June 20, 1959, to June 29, 1959, that I last saw the deceased alive on June 29, 1959, and that death occurred at 7 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
		DATE SIGNED	
ACTUAL SIGNATURE		J. S. HARP	
PHYSICIAN'S NAME (Type)		M.D. J. Elmer HARP	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		7-2-1959	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Rocky Springs Cem.		W. of Frederick, Md.	
		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		W. ADDRESS	
Lester F. Dailey Jr., Frederick, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR	
		DATE JUL 6 '59	
		24b. REGISTRAR'S SIGNATURE	
		Curtis S. HARP	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6778 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06754

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 5 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick		MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Frederick Rd Route 15	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Frederick Gen. Hosp.		1136 Englehardt Ave	
3. NAME OF DECEASED (Type or print)		First	Middle
Fannie		Lillian	Krauss
4. DATE OF DEATH		Month	Day
June 28 1959		Year	
5. SEX		6. COLOR OR RACE	7. MARRIED
Female		White	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
Oct 5, 1896		62 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		VIRGINIA U.S.A.	
13. FATHER'S NAME		14. MOTHER'S M AIDEN NAME	
SMITH MARTIN		Sallie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		MR. Frederick W. Krauss	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Fracture Base of skull - DUE TO		Hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Hours	
DUE TO		Hours	
(c)		Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED
11:00 a.m.		6/28 1959	While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	
Route 15		Frederick (County) Md (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED	
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		June 28, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		July 2, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
Meadowridge Cem.		Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
S. Truman Salter		3512 Frederick Govt.	
24a. REC'D BY REGISTRAR		24b. REG STRR'S SIGNATURE	
DATE JUL 1 '59		Arthur S. Kraus	
VS. AISMES(S)		SM 9/55	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 F. 1374 6-19-59 et
6779

116755

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		d. STREET ADDRESS West Main Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home				d. STREET ADDRESS West Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lena	Middle E	Last Lamar	4. DATE OF DEATH June	Month 5	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 28, 1877	9. AGE (In years lost birthday) 81 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Henry Newcomer				14. MOTHER'S MAIDEN NAME Louisa J. Harp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. David Young		Address Middletown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 3 weeks							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized Arteris Sclerosis (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 17, 1959 to June 5, 1959 , that I last saw the deceased alive on June 3, 1959 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Middleton DATE SIGNED 6-5-59							
ACTUAL SIGNATURE J. Elmer Harp							
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp Middletown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 7, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Reform cemetery		22d. LOCATION (City, town, or county) Middletown (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR Arthur & Kline		24b. REGISTRAR'S SIGNATURE	
ADDRESS Gladhill Company, Middletown, Md.				DATE JUN 9 '59			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, - Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6752

CERTIFICATE OF DEATH

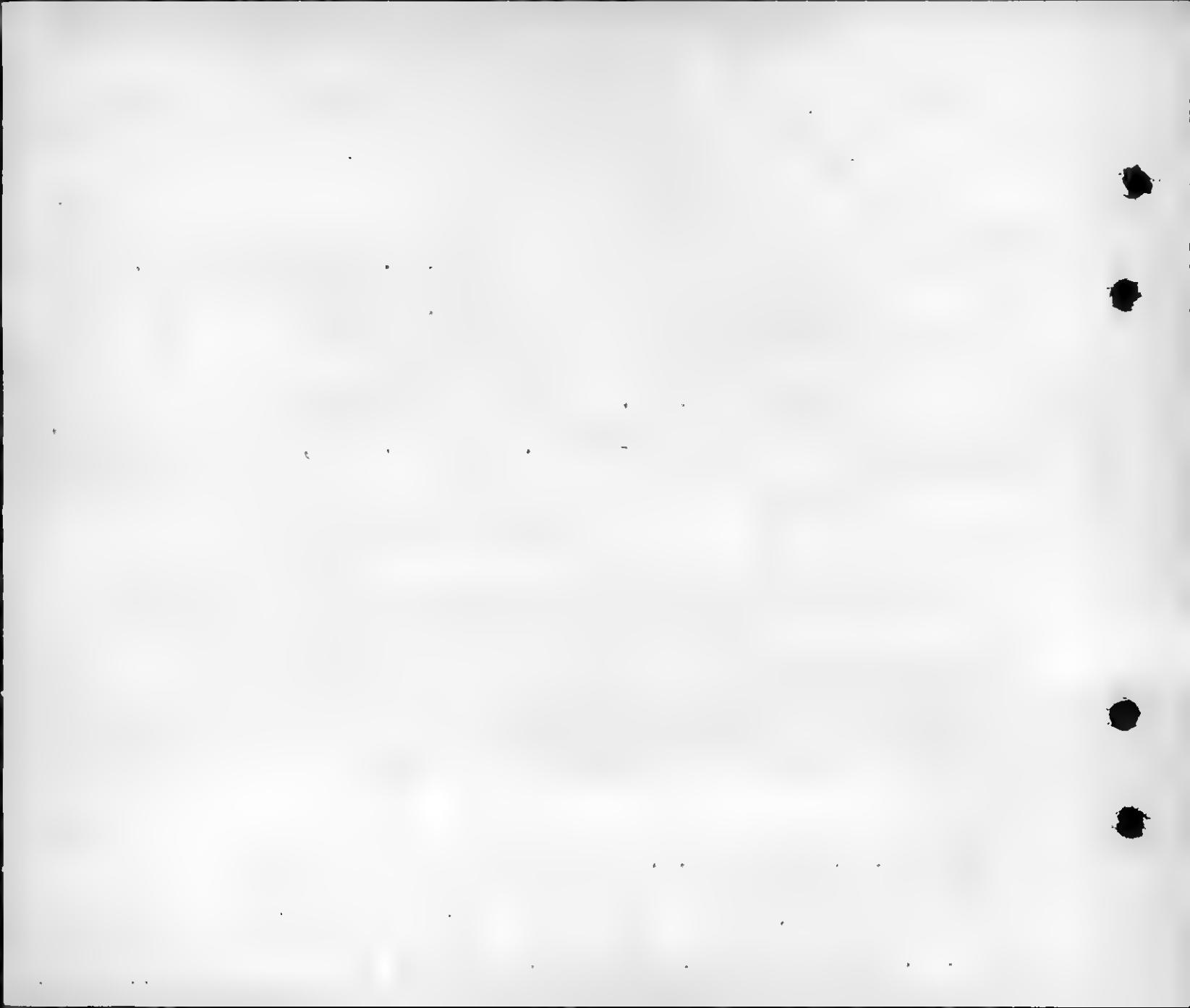
116756

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 42 East Fourth Street		d. STREET ADDRESS 42 East Fourth Street	
3. NAME OF DECEASED (Type or print) JOHN		First RAYMOND	Middle LONG, SR.
4. DATE OF DEATH June 20, 1959		Month June	Day 20 , Year 19 59
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 5, 1896		9. AGE (In years lost birthday) 63 yrs	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Elmer Long, Sr.	
14. MOTHER'S MAIDEN NAME Fannie Haupt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I	
16. SOCIAL SECURITY NO 214-10-2345		17. INFORMANT Mrs. Violet V. Long, Frederick, Maryland	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Congestive heart disease DUE TO (b) Cerebral hemorrhage, cerebral DUE TO (c) regret side
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20 , 1959, to June 24 , 1959, that I last saw the deceased alive on June 20 , 1959, and that death occurred at 5:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 6/22/59		ACTUAL SIGNATURE B. O. Thomas, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 24, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR JUN 23 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Traus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

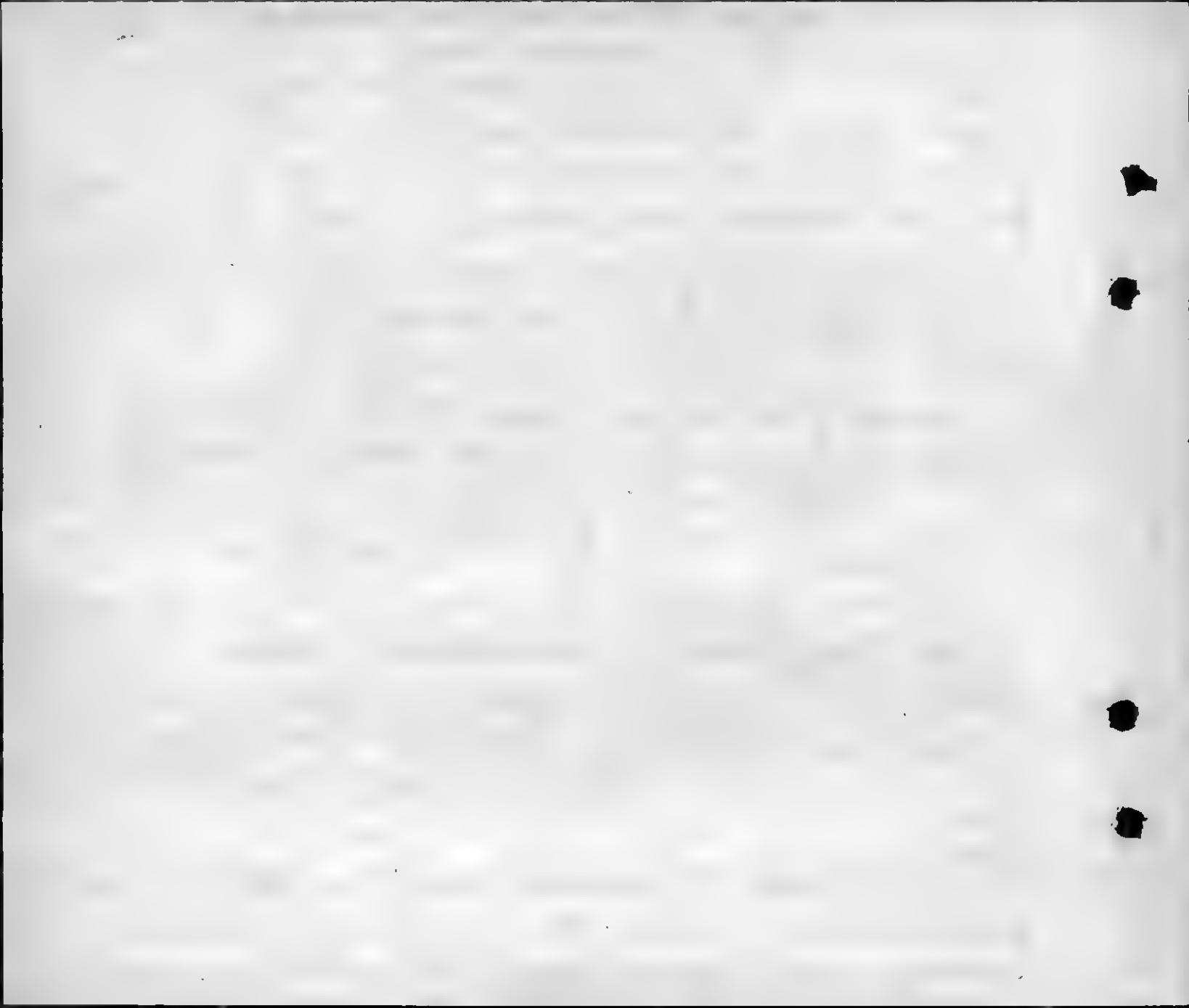
6780

CERTIFICATE OF DEATH

106757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Mount Airy		Frederick	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
5 yrs		X Same	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
109 Prospect Ave.		1 Same	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Jane	Last Lowman
4. DATE OF DEATH	Month June	Day 1	Year 1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 28, 1863
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Henry Dorsey	Annie Phillips		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]	16. SOCIAL SECURITY NO.	17. INFORMANT	Address 109 Prospect Ave Mrs. Margie Hoade - Mt. Airy, Md
NO	—	—	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Congestive Heart Failure 10 days		
+22.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.	DUE TO (b)	Arteriosclerotic Cardiopathy	25 years
	DUE TO (c)		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year 1959
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Mt. Airy	(County) Md.
20g. (City or town) Md.	(State)		
21. I certify that I attended the deceased from _____, 1955, to _____, 1959, that I last saw the deceased alive on _____, 1959, and that death occurred at 11:30 A.M., from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED	
ACTUAL SIGNATURE W.B. Culwell	M.D.	6/1/59	
PHYSICIAN'S NAME (Type) W.B. Culwell		maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-4-1959	22c. NAME OF CEMETERY CEMETORY Wine Grove	22d. LOCATION (City, town, or county) Mt. Airy
(State) Md.			(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE C.M. Waltz, Winfield, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. **Death** [redacted] **Page 4**
TO FUNERAL DIRECTOR: After it has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6753

CERTIFICATE OF DEATH

106758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 113 E. 5th street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 E. 5th street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Vannie		First Vannie	Middle Agnes	Last Luby	4. DATE OF DEATH 6 30 1959	Month 6	Day 30	Year 1959
5. SEX Female	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/ 1/80		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Calvin T. Luby			14. MOTHER'S MAIDEN NAME Hertes Brown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 217-07-0731		INFORMANT Pauline Hammond		Address 113 E. 5th Street		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42 J. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arterio-venous fistula (b) DUE TO Arteriosclerotic heart disease (c) INTERVAL BETWEEN ONSET AND DEATH Never years								
PART II. OTHERS MENTIONED CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 6/2, 1959 to 6/30, 1959 , that I last saw the deceased alive on 6/29, 1959 , and that death occurred at 11:40 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE James B. Thomas PHYSICIAN'S NAME (Type) M.D. 228 N. Market Street ADDRESS (Street, city or town, state) Frederick, Maryland DATE SIGNED 7/3/59								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/59		22c. NAME OF CEMETERY OR CREMATORIAL Fairview		22d. LOCATION (City, town, or county) Frederick		
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks		ADDRESS 24 W. All Saints		24a. REC'D BY REGISTRAR DATE JUL 9 1959		24b. REGISTRAR'S SIGNATURE Charles E. Hicks		



1

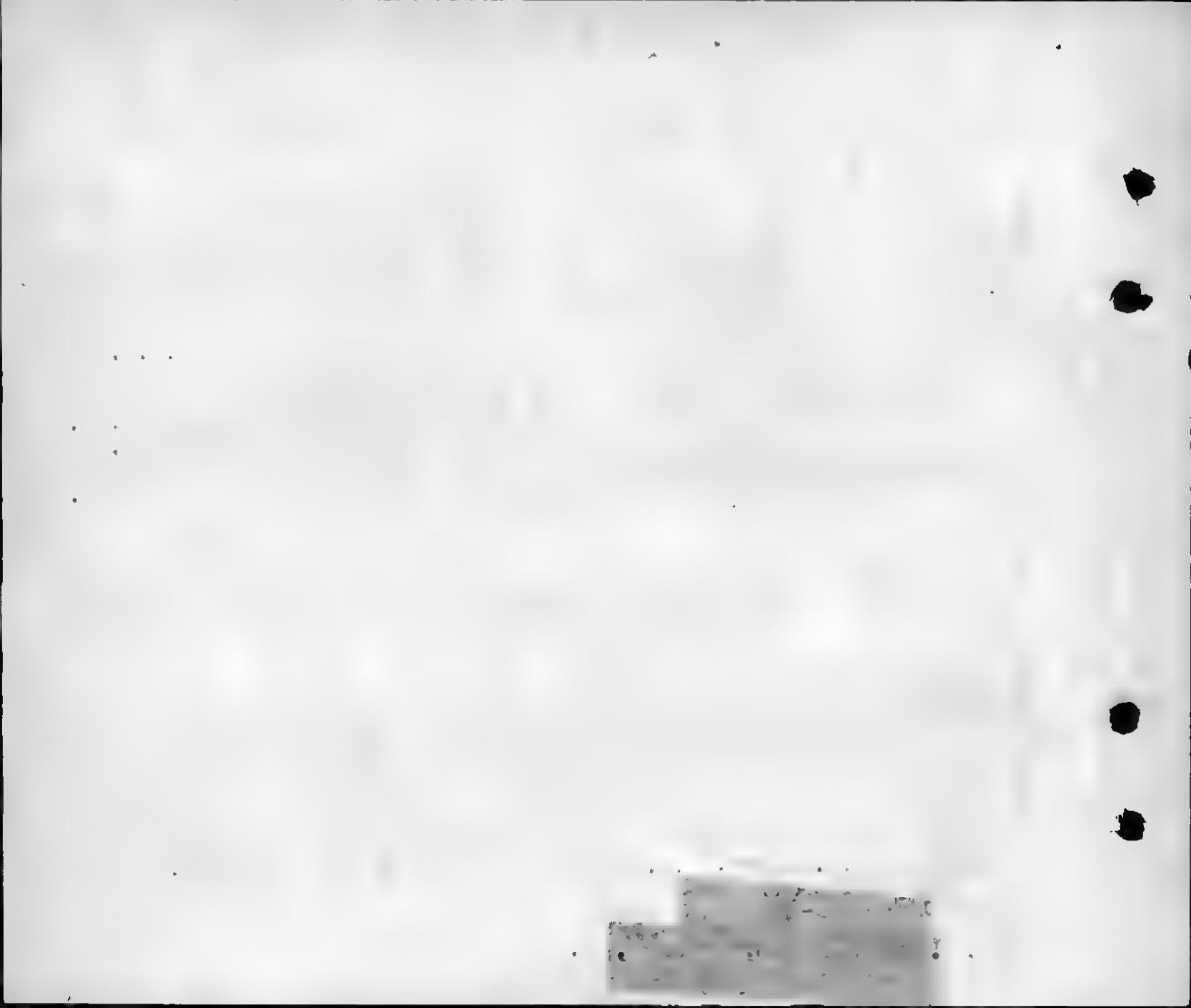
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16760

Reg. Dist. No.

1
REPUTY MEDICAL EXAMINER This certificate shall be submitted within 24 hours after death
 execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the
 Chief Medical Examiner's Office along with form PH3. Page 5 may be retained by the
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, ~~cremation~~
 or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Frederick MARYLAND		Maryland Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF -DECEASED (Type or print)		First Douglas	Middle Wayne
		Last Moss	4. DATE OF DEATH June 30
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> August 29, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Frederick County	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Elmer L Moss		Anna Lee Delaughter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Address Frederick, Md. Anna Lee Moss, 4 25 S. Market St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virial Pneumonitis</u> DUE TO <u>492X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO <u>492X</u> (b)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 30, 1959	
EXAMINER'S NAME (Type)		B.O. Thomas, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-59	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) Locust Valley Cemetery Frederick County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		ADDRESS	
		24a. RECD BY REGISTRAR DATE JUL 2 '59	
		24b. REGISTRAR'S SIGNATURE <u>Cuthbert & Krause</u>	



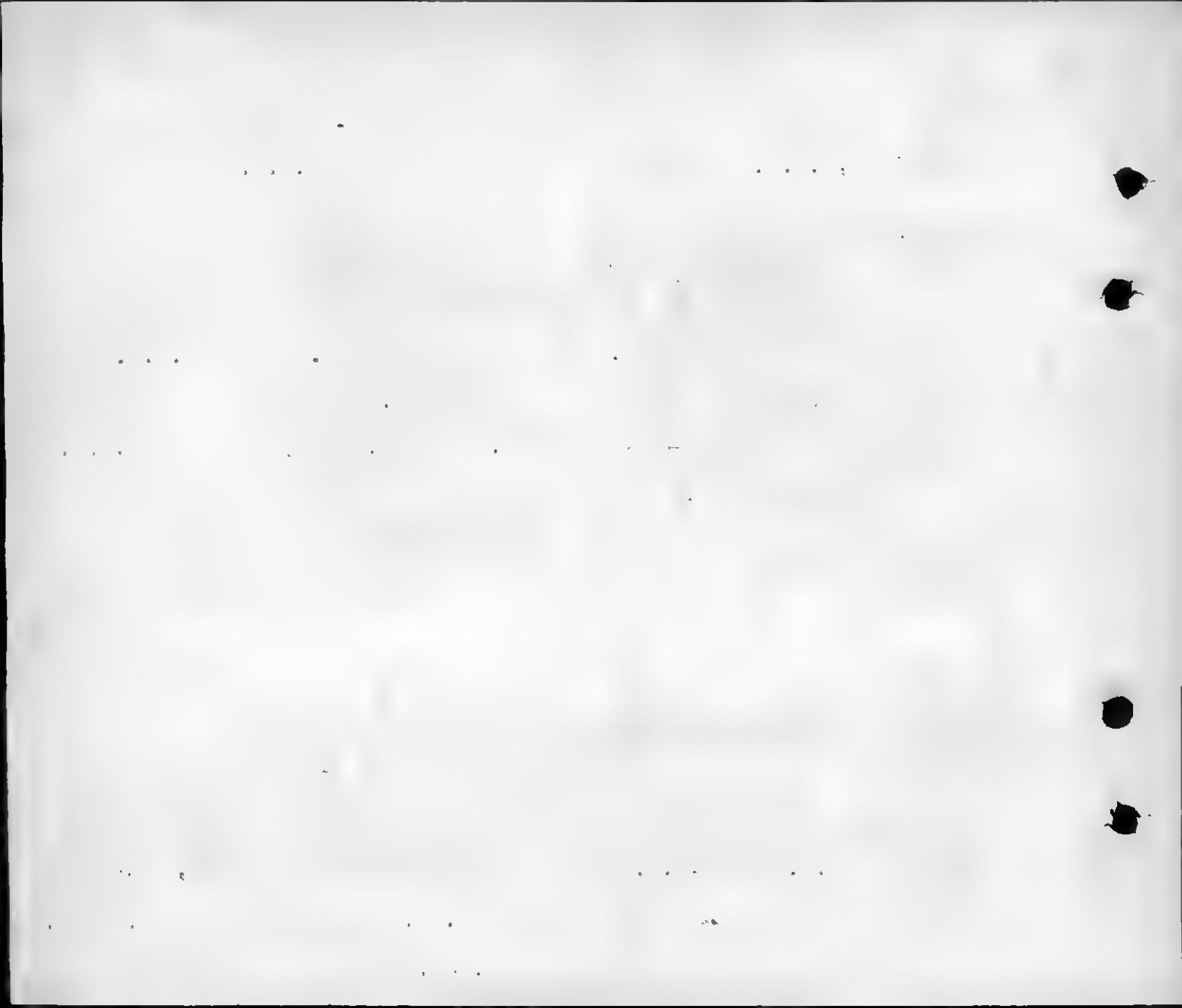
1
FOR STATE
HEALTH DEPT.

Items 18-21 Fill MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6781 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06761

TO MEDICAL EXAMINER: This certificate would be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 to be retained for our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If out'side corporate limits, write RURAL and give nearest town) Myersville, R.F.D.2		c. LENGTH OF STAY IN b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If out'side corporate limits, write RURAL and give nearest town) Myersville R.F.D.2	
3. NAME OF DECEASED (Type or print) Austian		4. DATE OF DEATH Month June Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH January 10, 1916 43 yrs	8. AGE (In years (at birthday) 43 yrs
9. IF UNDER 1 YEAR Months 0 Days 0	10. IF UNDER 24 HRS Hours 0 Min. 0	11. BIRTHPLACE (State or foreign country) Frederick Co.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own gen. farm	
13. FATHER'S NAME Charles S. Myers		14. MOTHER'S MAIDEN NAME Amanda C. Moser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-30-9175 17. INFORMANT Mrs. Austin P. Myers, Myersville, R.D.2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Browning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Alcoholism (c) Noturol - 1000 mg. 1/2		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) Fell in small dairy Spring, head submerged under water, no other part of body in water. Alcohol from spinal fluid.	
20c. TIME OF INJURY Hour 0 a. m. - 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm (Home)		20f. (City or town) near Myersville (County) Fred (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Noturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas, M.D.</i>		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		DATE SIGNED June 19, 1959	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Walk U.		22d. LOCATION (City, town, or county) B. Nr Myersville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul F. Bittle</i>		24a. REC'D BY REGISTRAR Arthur S. Kline	
ADDRESS Paul F. Bittle, Myersville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
DATE JUN 23 '59			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06762

Item 8 20 b to f File 14 3-44 711118

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Frederick	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Frederick	c. LENGTH OF STAY IN Tb	a. STATE Maryland b. COUNTY Frederick					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Frederick Memorial Hospital	/Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
3. NAME OF DECEASED (Type or print)	Edward Ray	First	d. STREET ADDRESS					
4. DATE OF DEATH	Naill	Middle	e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX	Male	6. COLOR OR RACE	White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
					June 18, 1959	yes		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Frederick Co.	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Bernard R. Naill	Janet L. Naill		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Janet L. Naill, Mt. Airy R.F.D. 4	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
762.0	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last,	DUE TO
	Septicemia
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
	No injury				
20c. TIME OF INJURY Month, Day, Year Hour p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fr. d. Mem. Hosp	20f. (City or town) Frederick, Frederick Md.	(County) Frederick	(State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE	B.O. Thomas, M.D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR Crematory	22d. LOCATION (City, town, or county)	June 22, 1959	
Burial	6-23-59	Woodlawn	Frederick Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE		
C. M. Watz	Winfield, Md	JUN 24 1959	John L. Moore		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

186763

6756

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland		b. INSTITUTION: Residence before admission b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Franklin G.		First	Middle	Last	4. DATE OF DEATH June	Month	Day	Year	27 1959
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH 10/4/1911	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY grocery store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Franklin G. Norris		14. MOTHER'S MAIDEN NAME Minnie E. Powers							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-10-9219		17. INFORMANT Mrs. Mary Norris, Middletown, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Subarachnoid hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 9 days			
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Congenital aneurysm of the circle of Willis				Lifetime			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from 6/19 1959 to 6/27 1959 that I last saw the deceased alive on 6/27 1959 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Henry V. Chase		M.D. 4 E. Church St				ADDRESS (Street, city or town, state) Frederick, Maryland			
PHYSICIAN'S NAME (Type) Henry V. Chase						DATE SIGNED 6/27/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/30/1959		22c. NAME OF CEMETERY OR CREMATORIAL Locust Valley Ch. of God Cem.		22d. LOCATION (City, town, or county) Fredk. Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		ADDRESS				24a. REC'D BY REGISTRAR DATE JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4
may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



1 Items 2 to 6 to MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Film G-244 rs MEDICAL EXAMINER'S CERTIFICATE OF DEATH

106764

Reg. Dist. No.

FOR STATE
HEALTH DEPT.



DEPUTY MEDICAL EXAMINER This certificate should be executed in pencil in item 18. Give Pages 1, 2, and 7 to the Funeral Director. Page 4 should be handed to them if Medical Examiner's Office along with form PM3. Page 5 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY	Frederick	6782	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	Maryland	b. COUNTY	Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Emmitsburg R.F.D.	c. LENGTH OF STAY IN 16	Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Emmitsburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Frederick Memorial Hospital	d. STREET ADDRESS	RD #2					
3. NAME OF (Type or print)	George	First	Middle	e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX	Male	6. COLOR OR RACE	White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	Oct. 4, 1881	9. AGE (in years last birthday)	77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	LABOR	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	Maryland	12. CITIZEN OF WHAT COUNTRY?	U.S.A.	
13. FATHER'S NAME	John Peddicord	14. MOTHER'S MAIDEN NAME	Ellen Butts					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) If yes, give war or dates of service)	NO	16. SOCIAL SECURITY NO		17. INFORMANT	John Peddicord	Address	Baltimore, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				Acute Trache-Bronchitis				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				due to inhaling smoke and flame				
(b)				2 days				
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pouring kerosene on live coals, blazed into face				
20c. TIME OF INJURY Month, Day, Year Hour		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
6/17 1959			Home	Emmitsburg, RFD; Fred.	Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE	<i>B.O. Thomas, M.D.</i>				DATE SIGNED			
EXAMINER'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM				22d. LOCATION (City, town, or county)	R.D. 2	
Burial	June 22, 1959	St. Anthony's				Emmitsburg, Frederick Co. Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR JUN 23 '59				24b. REGISTRAR'S SIGNATURE		
<i>C. E. Wilson</i>	Emmitsburg, Md.					<i>Arthur L. Kraus</i>		
VS A15ME 5M 2/57								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

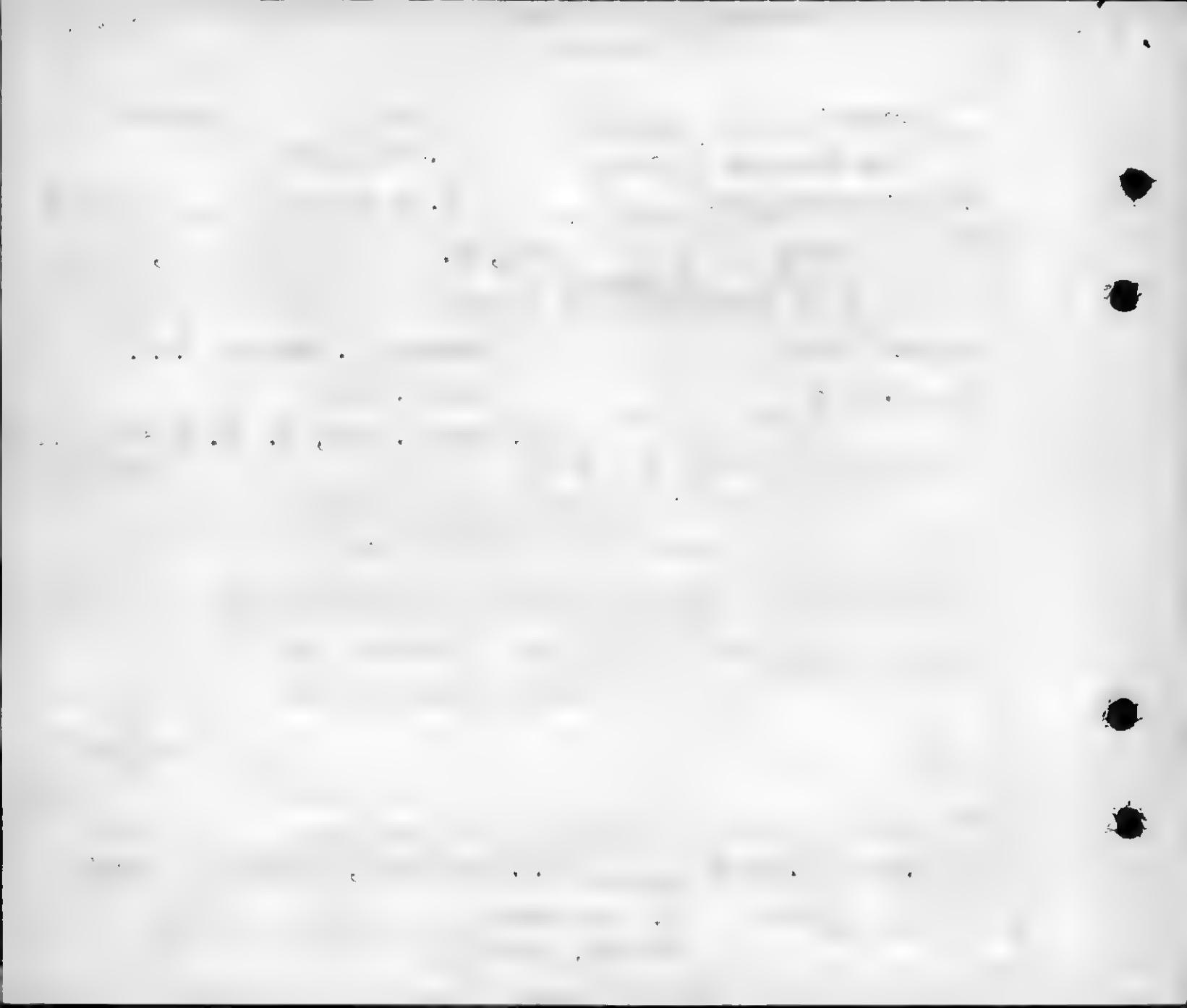
6783 CERTIFICATE OF DEATH

116765

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. LENGTH OF STAY IN lb 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. #2 Middletown		d. STREET ADDRESS Rt. #2 Middletown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley View Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) George		First William	Middle Poole, Sr.	Last 67	4. DATE OF DEATH June 7, 1959	Month June	Day 7	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5/8/1892	9. AGE (In years last birthday) 67	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ernest F. Poole				14. MOTHER'S MAIDEN NAME Annie R. Topper				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yea, no, or unknown) work		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. George W. Poole, Sr.		Address Rt. #2 Middletown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Cerebral hemorrhage		Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 wks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Middletown	(County) Maryland	(State) Md.			
21. I certify that I attended the deceased from March , 1958, to June 6, 1959 , that I last saw the deceased alive on May 23, 1959 , and that death occurred at 12:28 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Middleton, Md. DATE SIGNED 6/8/59								
ACTUAL SIGNATURE <i>Dr. Kenneth C. Hanson</i>	PHYSICIAN'S NAME (Type) Dr. Kenneth C. Hanson	M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/11/59	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland	(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Dailey</i>	ADDRESS Frederick, Maryland	24a. REC'D BY REGISTRAR JUN 12 1959	24b. REGISTRAR'S SIGNATURE <i>John A. Moore</i>					



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

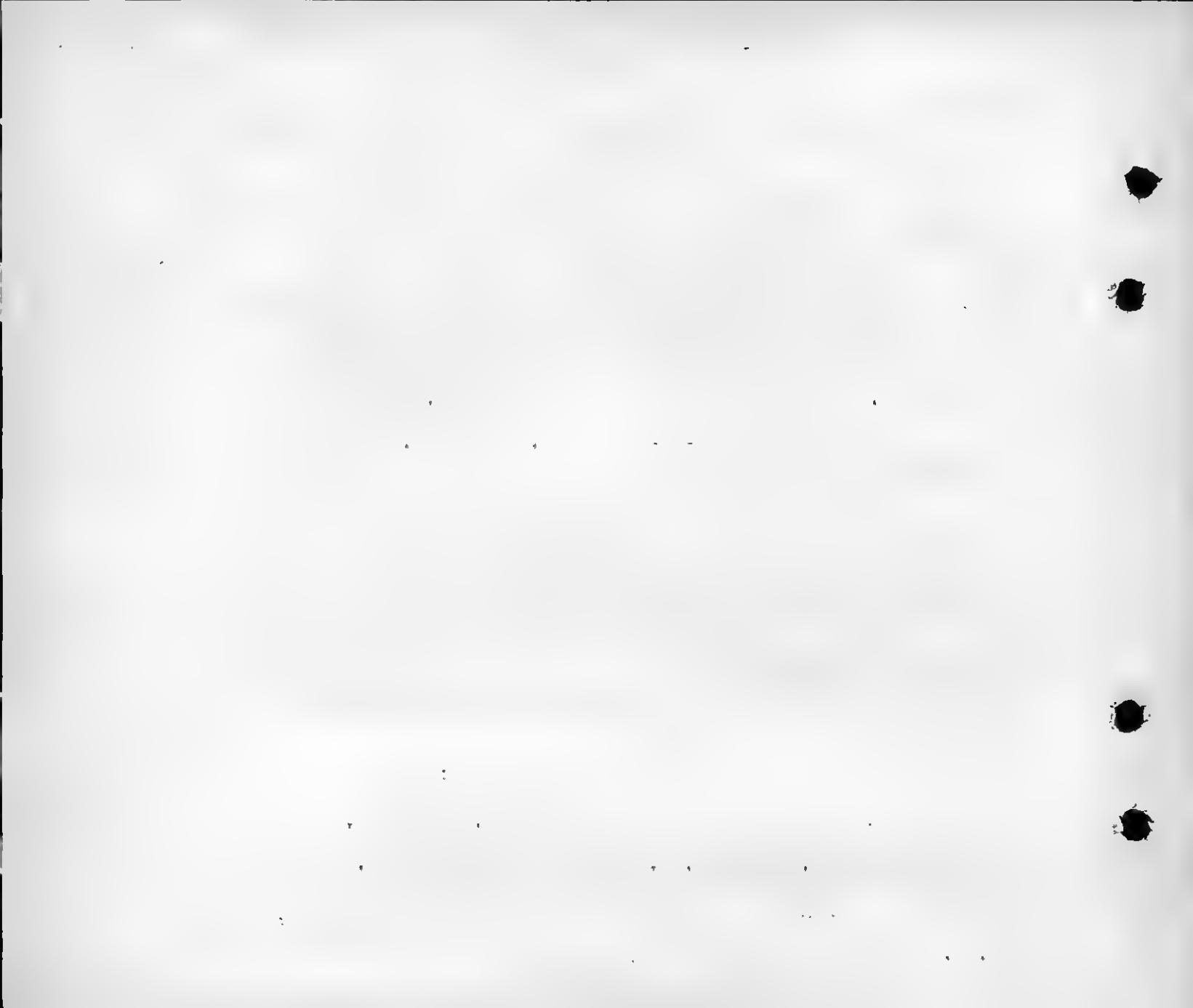
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6757 CERTIFICATE OF DEATH

116766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 30 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 543 North Market Street			d. STREET ADDRESS 543 North Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle ZIMMERMAN	Last RENN	4. DATE OF DEATH Month June Day 29, Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 30 Oct 1901	9. AGE (In years from birthday) 57 yrs	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner			10b. KIND OF BUSINESS OR INDUSTRY Restaurant Business		11. BIRTHPLACE (State or foreign country) Adamstown, Maryland
13. FATHER'S NAME William H. Renn			14. MOTHER'S MAIDEN NAME Edith G. Smith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-32-4365		17. INFORMANT Mrs. Mildred F. Renn (Same as item #1)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO 10.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Anteriorobtuse heart Disease (c)			INTERVAL BETWEEN ONSET AND DEATH 30-45 min		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 19 , 1959 to June 29 , 1959, that I last saw the deceased alive on June 28 , 1959, and that death occurred at 6:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henry V. Chase, M.D. 4 E. Church St. DATE SIGNED 29 June 1959					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Henry V. Chase, M. D. Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-59		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick, Maryland				(State)	
23 FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS 24a. REC'D BY REGISTRAR DATE JUL 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
 may be retained by the hospital or attending physician.

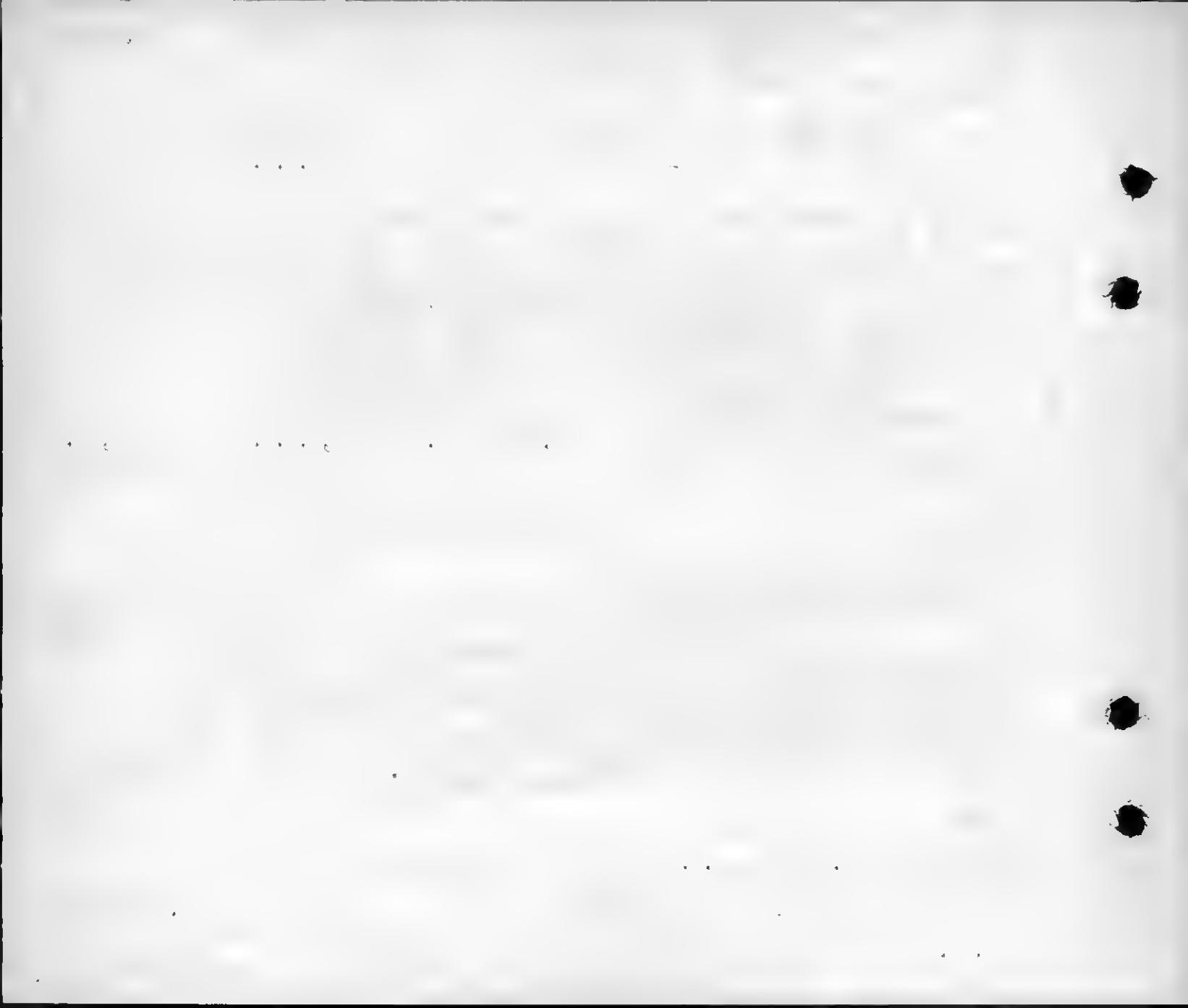
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6758 CERTIFICATE OF DEATH

Reg. Dist. No. **106767**

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1-Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#7	
3. NAME OF DECEASED (Type or print) ISABELL		First RAY	Middle SCHULTZ
4. DATE OF DEATH June 7, 1959		5. SEX Female	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1899	
9. AGE (In years last birthday) 59		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home	
10c. BIRTHPLACE (State or foreign country) Maryland		14. MOTHER'S MAIDEN NAME Eleanor Main	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-10-1979E	
17. INFORMANT Mr. Albert W. Schultz, R.F.D.#7, Frederick, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral vascular accident	
19. MEDICAL CERTIFICATION		20. INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Frederick (State) Maryland	
21. I certify that I attended the deceased from April 1953 to 6-7-1959 , that I last saw the deceased alive on 6-7-1959 , and that death occurred at 4:40 P.M. from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) East Church Street	
ACTUAL SIGNATURE <i>Rex R. Martin</i>		DATE SIGNED 6/8/59	
23. PHYSICIAN'S NAME (Type) Rex R. Martin, M.D.		24. Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Rocky Springs Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JUN 10 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6759

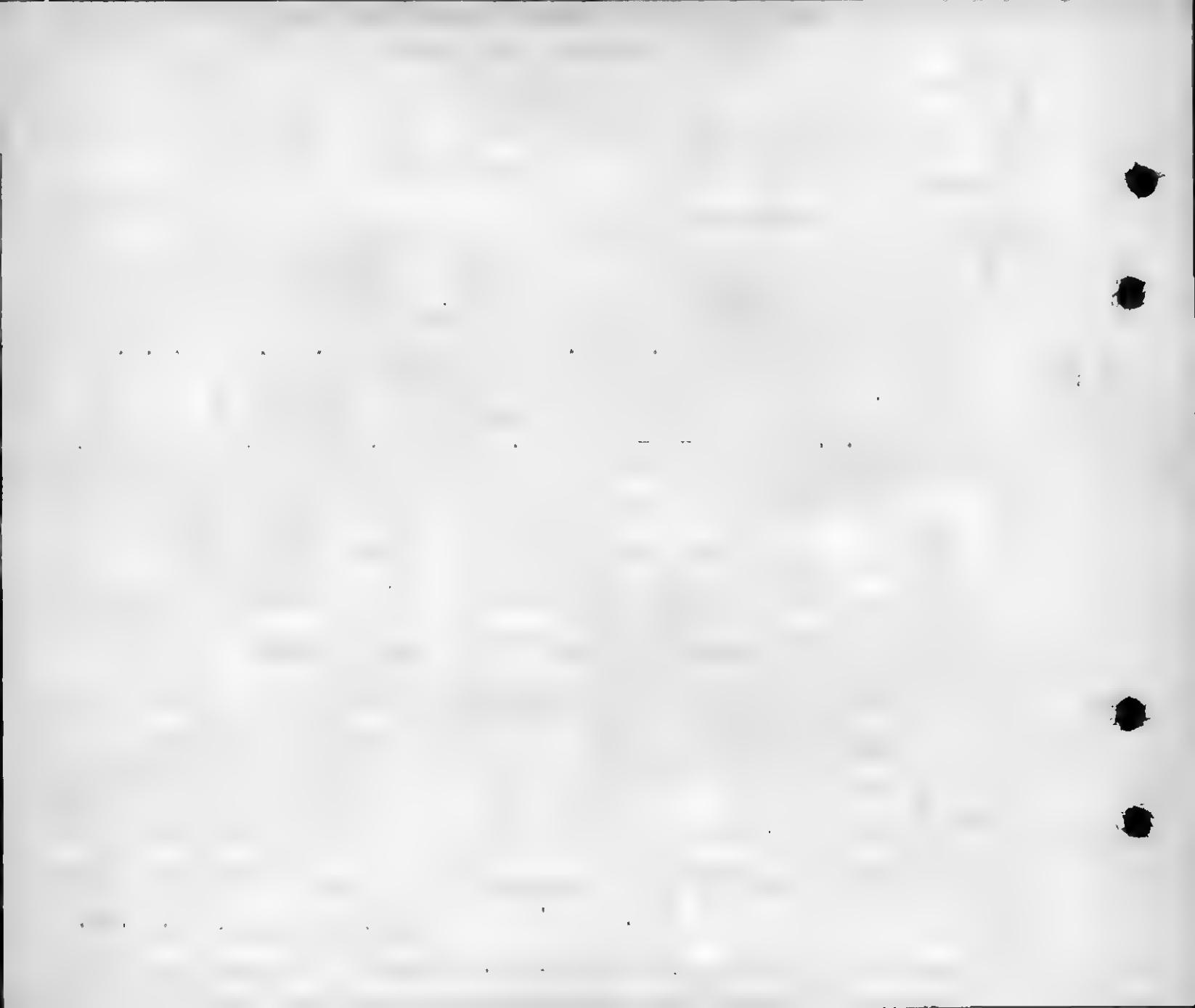
CERTIFICATE OF DEATH

06768

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 4 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEM. HOSP		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELMER F ranklin		4. DATE OF DEATH Last SHEPLEY Month JUNE Day 3 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1899
9. AGE (in years last birthday) 59 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Own Gen. Mdse.	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John O. Shepley		14. MOTHER'S MAIDEN NAME Laura C. Brandenburg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. # 1 219-20-0770	
17. INFORMANT Mrs. Miriam P. Shepley, Myersville, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral Thrombosis following Imobilization Rheumatic Heart dis. with mitral and aortic valve stenosis + au. fibrillation 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Diabetes mellitus (142)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bleeding peptic ulcer (2105)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1957, to _____, 1957, that I last saw the deceased alive on _____, 1959, and that death occurred at _____ P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHARLES H. CONLEY, JR. M.D. Professional 13608 Frederick, Md.			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		DATE SIGNED 6/5/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 8, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Lutheran		22d. LOCATION (City, town, or county) Myersville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		ADDRESS Paul F. Bittle, Myersville, Md.	
		24a. REC'D BY REGISTRAR Arthur S. Thomas	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6784

CERTIFICATE OF DEATH

06769

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After 11 a.m. OR: After 11 a.m. the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, nr. Libertytown</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Libertytown</i>	
d. STREET ADDRESS <i>—</i>		d. STREET ADDRESS <i>—</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ISAAC</i>		First <i>SMITH</i>	Middle <i>—</i>
4. DATE OF DEATH Month <i>JUNE</i>	Day <i>30</i>	Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 31, 1873</i>
9. AGE (In years less birthday) <i>86 yrs.</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>	12. IF UNDER 24 HRS. Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>miner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Copper mine</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Anthony Smith</i>		14. MOTHER'S MAIDEN NAME <i>Susanne Crum</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mr. Charles T. Smith, Fred, Md.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>			
DUE TO <i>42-1</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Myocardial infarction</i>			
DUE TO <i>—</i>			
(c) <i>Arteriosclerotic cardiovascular disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension of right side of face & eye.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>—</i> (State) <i>—</i>	
21. I certify that I attended the deceased from <i>July</i> , 1957, to <i>July 30</i> , 1959, that I last saw the deceased alive on <i>June 19</i> , 1959, and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E.A. Dettbarn</i>		ADDRESS (Street, city or town, state) <i>Walkersville, Md.</i> DATE SIGNED <i>July 1959</i>	
PHYSICIAN'S NAME (Type) <i>E.A. DETTBARN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 3, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Chapel Cemetery</i>		22d. LOCATION (City, town, or county) <i>nr. Libertytown, Md.</i> (State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.C. Barton, Walkersville, Md.</i>		ADDRESS <i>—</i>	
24a. REC'D BY REGISTRAR DATE <i>JUL 6 59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles J. Smith</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6785 CERTIFICATE OF DEATH

106770

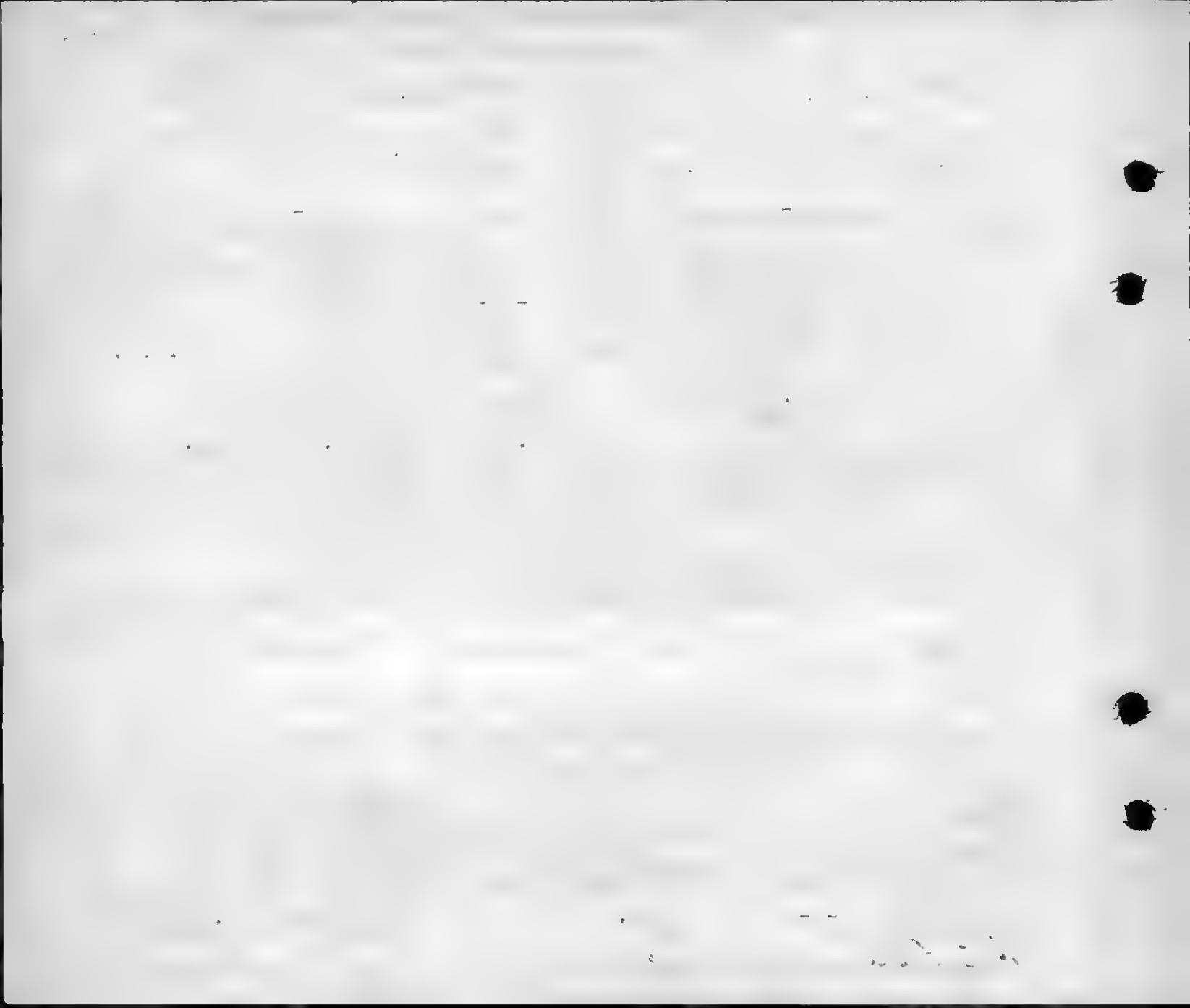
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Foster	Middle Raymond	Last Snoots
4. DATE OF DEATH	Month 6	Day 29	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-1902
9. AGE (in years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman	10b. KIND OF BUSINESS OR INDUSTRY Fruit Growers	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Harry C. Snoots	14. MOTHER'S MAIDEN NAME Alice Davis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT	Address Mrs. Marion Snoots, Knoxville, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart attack, sudden</i> DUE TO <i>Exhaustion, sudden</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Exhaustion</i> DUE TO <i>Exhaustion</i> <i>34 x.</i> cause (c) <i>Exhaustion</i> <i>15-46.</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1944 to 1945 that I last saw the deceased alive on 1945 , and that death occurred on 1945 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John C. Davis</i>	ADDRESS (Street, city or town, state) Petersville, Maryland DATE SIGNED 7-2-59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-59	22c. NAME OF CEMETERY OR CREMATORIAL St. Marks
22d. LOCATION (City, town, or county) Petersville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John C. Davis</i>		24a. REC'D BY REGISTRAR DATE JUL 2 1959	24b. REGISTRAR'S SIGNATURE <i>John C. Davis</i>
ADDRESS Brunswick, Maryland			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

106771

6760 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b RURAL and give nearest town JEFFERSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) INFANT		4. DATE OF DEATH JUNE 16 1959	Month Day Year JUNE 16 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JUNE 14 1959	9. AGE (In years lost birthday) yrs 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PAUL V SCHAFFNER	
14. MOTHER'S MAIDEN NAME BARNES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —	
16. SOCIAL SECURITY NO. —		17. INFORMANT PAUL SCHAFFNER Jefferson MD	Address Jefferson MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure 16. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. —		INTERVAL BETWEEN ONSET AND DEATH —	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) —
21. I certify that I attended the deceased from 14 June 1959 to 16 June 1959 that I last saw the deceased alive on 16 June 1959 , and that death occurred at 2 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Donal J. Heldrich M.D.		ADDRESS (Street, city or town, state) 220 N. MARKET ST	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 16-59	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet
22d. LOCATION (City, town, or county) FREDERICK MD		22e. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frederick J. Heldrich Jr.		24a. REC'D BY REGISTRAR DATE JUN 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thorne



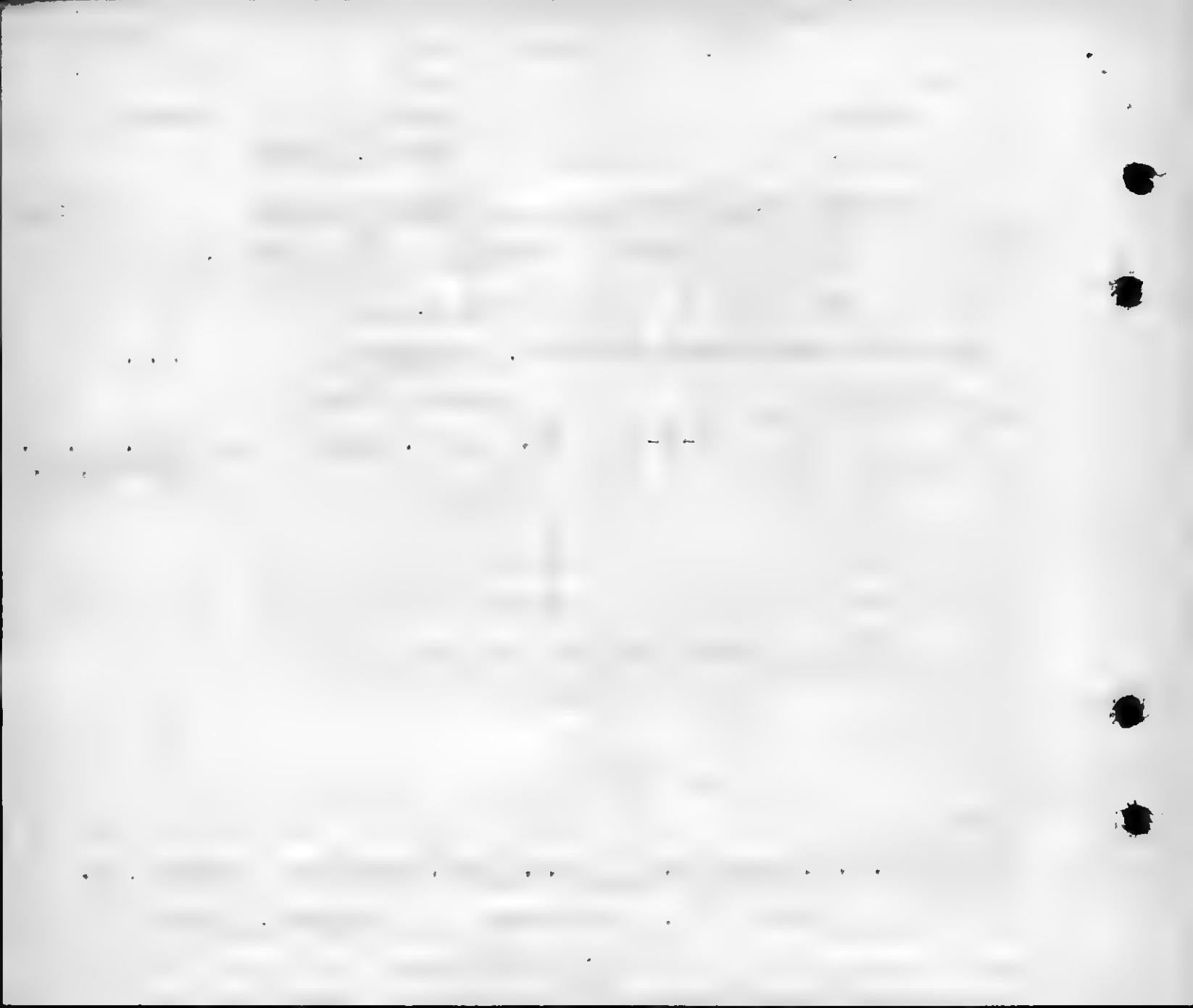
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6761 CERTIFICATE OF DEATH

06772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb over 45 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland		d. STREET ADDRESS 332 East 3rd Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Snively		First Snively	Middle Elsworth	Lost Spangler	4. DATE OF DEATH June 29,	Month June	Day 29	Year 1959	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH November 21, 1891	9. AGE (In years lost birthday) 67	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Molder at the Frederick Iron and Steel Co.		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Harvey Spangler				14. MOTHER'S MAIDEN NAME Anna Mary Robinson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 214-10-3474		17. INFORMANT Mrs. Jessie E. Spangler (wife)		Address 332 E. 3rd. St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Major accident in Engage		DUE TO Chilled to the bone		DUE TO Old coronary thrombosis		DUE TO 4 days		FREQUENT ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 420.1		(b) Chilled to the bone		(c) Old coronary thrombosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Frederick, Md.		(State)	
21. I certify that I attended the deceased from June 29, 1959 to July 24, 1959 , that I last saw the deceased alive on June 29, 1959 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 1201 3rd St., Frederick, Md.									
DATE SIGNED July 24, 1959									
ACTUAL SIGNATURE R. C. Williams									
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr.		M.D. 228 N. Market Street Frederick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/59		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Snively Jr.		ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR Jul 6 59		24b. REGISTRAR'S SIGNATURE Orville S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper.
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6762 CERTIFICATE OF DEATH

06773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 4/1945	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home for the Aged		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BETTIE		First ANN	Middle SPECHT
4. DATE OF DEATH Month June 22,		Day 19	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Dec 1864
9. AGE (In years at birthday) 94		10. IF UNDER 1 YEAR Months 0	
11. BIRTHPLACE (State or foreign country) Maryland		12. IF UNDER 24 HRS Days 0	
13. FATHER'S NAME Michael Specht		14. MOTHER'S MAIDEN NAME Elizabeth Copeland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Home for the Aged Records (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Arthritis - Sclerotic heart dis. (c)		20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19 40 , to 6/22 , 19 57 , that I last saw the deceased alive on 18 June , 19 57 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St. DATE SIGNED 24 June 1959			
ACTUAL SIGNATURE Charles H. Conley, Jr., M.D.		PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-59	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery
22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JUN 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Moore



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										116774
6763 CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					
d. NAME OF HOSPITAL (If not in hospital, give street address) ORGANIZATION Frederick Memorial Hospital					d. STREET ADDRESS 124 East Seventh Street			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		(Also known as John S. W. Spurrier) SAMUEL WESLEY RALPH SPURRIER			4. DATE OF DEATH June 29, 1959	Month	Day	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12 March 1908			9. AGE (In years from birthday) 51 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Finisher			10b. KIND OF BUSINESS OR INDUSTRY Cement Construction		11. BIRTHPLACE (State or foreign country) Ceresville, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Rosco C. Spurrier					14. MOTHER'S MAIDEN NAME Mary Agnes Layman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 214-10-5245		17. INFORMANT Mr. Rosco C. Spurrier (Same as item #2)			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3IX DUE TO Cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 60 hrs.										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Hypertensive vascular disease DUE TO Year										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 12045 P		(County)	(State)
21. I certify that I attended the deceased from June 27, 1959 to June 29, 1959 that I last saw the deceased alive on June 29, 1959 , and that death occurred at 7 E. Church St. ADDRESS (Street, city or town, state) Robert S. Turner, Jr., M.D. DATE SIGNED ACTUAL SIGNATURE 30 June 1959										
22. PHYSICIAN'S NAME (Type) Robert S. Turner, Jr., M. D. Frederick, Md.										
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-59		22c. NAME OF CEMETERY OR CREMATORIUM Frederick Memorial Park			22d. LOCATION (City, town, or county) Frederick, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland					24a. REC'D BY REGISTRAR DATE JUL 2 '59		24b. REGISTRAR'S SIGNATURE Collier S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116775

6786 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Walkersville</i>		b. COUNTY <i>Frederick</i>	
c. LENGTH OF STAY IN 1b <i>28 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Walkersville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CHESTER WILLIAM STINE, SR.</i>		First <i>CHESTER</i>	Middle <i>WILLIAM</i>
		Last <i>STINE, SR.</i>	4. DATE OF DEATH <i>June 2 1959</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH <i>Aug 12 1904</i>	
9. AGE (In years last birthday) <i>54 yrs</i>		10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tenant</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joseph Stine</i>		14. MOTHER'S M AIDEN NAME <i>Mertie Ruby</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>222-30-7538</i>	
17. INFORMANT <i>Mrs. Chester W. Stine, Walkersville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>	
DUE TO (b) <i>Carcinoma, tail of pancreas</i>		9 months	
DUE TO (c) <i>metastasis to liver, spine</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>February 1959</i> to <i>2 June 1959</i> , that I last saw the deceased alive on <i>2 June 1959</i> , and that death occurred at <i>2:30 PM</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Walkersville, Md</i>	
ACTUAL SIGNATURE <i>James E. Stoner Jr.</i>		DATE SIGNED <i>3 June 1959</i>	
PHYSICIAN'S NAME (Type) <i>JAMES E. STONER, JR.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 5, 1959</i>		22b. DATE THEREOF <i>Forest Grove Cem.</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Forest Grove Cem.</i>		22d. LOCATION (City, town, or county) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. C. Barton</i>		24a. REC'D BY REGISTRAR DATE JUN 4 '59	
ADDRESS <i>Walkersville, Md</i>		24b. REGISTRAR'S SIGNATURE <i>Editor of Health</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To F UNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper. If any page 3 is lost, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death, the law requires that the death certificate be filed in by the funeral director.



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

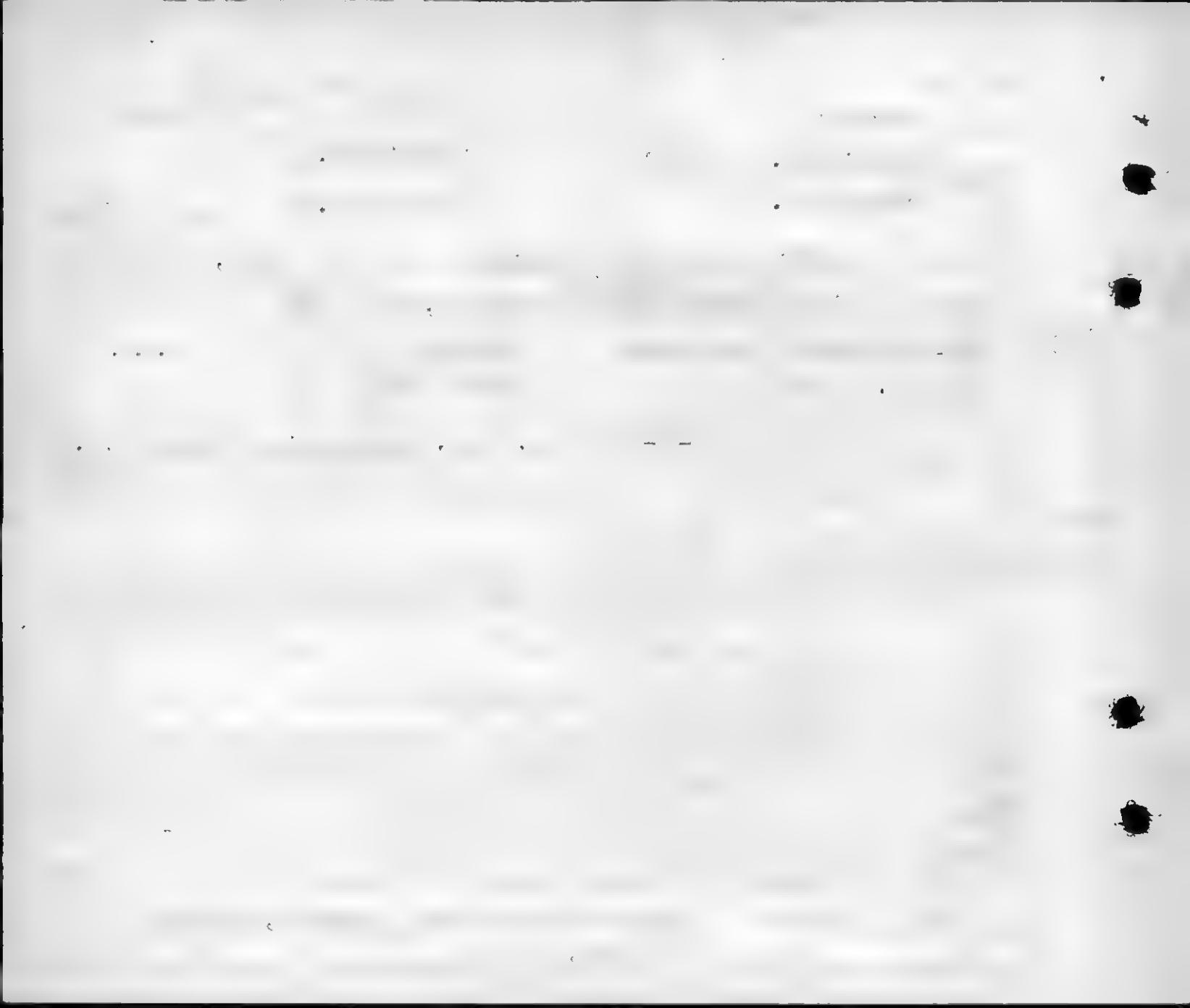
6787

CERTIFICATE OF DEATH

06776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Rt. #4		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Rt. #4		d. STREET ADDRESS Frederick Rt. #4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Rt. #4						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Harry		First	Middle I	Last Stockman	4. DATE OF DEATH June 6, 1959	Month June	Day 6	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1893	9. AGE (in years, last birthday) 66 65 yrs	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 6	Hours 5	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer and steel worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Nathan C. Stockman		14. MOTHER'S MAIDEN NAME Innie Kimmel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-02-7972		17. INFORMANT Mrs. Mae P. Stockman (wife)		Address Frederick Rt. #4		
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Carcinoma Rectum inext Tuberculosis Cirrhosis of liver				INTERVAL BETWEEN ONSET AND DEATH 4 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____		4/14, 1957, to 6/6/60, 1959		M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE A. H. F. Jr.		M.D. A. H. F. Jr.				DATE SIGNED 6/14/59		
PHYSICIAN'S NAME (Type) AT 121-15								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/59		22c. NAME OF CEMETERY OR CREMATORIAL Frederick Memorial Park		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey Jr.		ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JUN 12 59		24b. REGISTRAR'S SIGNATURE Carlyle S. House		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6788 CERTIFICATE OF DEATH

116777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#5		c. LENGTH OF STAY IN 1b 4 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#5				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bowers Road				d. STREET ADDRESS Bowers Road		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First HANNAH	Middle ELVIRA	Last STOUGH	4. DATE OF DEATH June	Month 7	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1877	9. AGE (In years with birthday) 82 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jeremiah E. Brown				14. MOTHER'S MAIDEN NAME Martha Alice Freeman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes or no or unknown] No		16. SOCIAL SECURITY NO. 179-20-3653D		17. INFORMANT Mrs. Austin D. Taylor-Same as Item #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 194x DUE TO <i>Senility</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 6-1-53, 19 to 6-7, 1959, that I last saw the deceased alive on 6-2-59, and that death occurred at 3:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Rex R. Martin</i> M.D. East Church Street DATE SIGNED 6/8/59 PHYSICIAN'S NAME (Type) Rex R. Martin, M.D. Frederick, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Westmoreland Memorial Park		22d. LOCATION (City, town, or county) Greensburg, Penna.		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 10 1959		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116778

6789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. F. D. #1 Jefferson		c. LENGTH OF STAY IN lb 50 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. F. D. #1 Jefferson		d. STREET ADDRESS Near Jefferson		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Jefferson						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ROY		First ALBURTUS	Middle SUMMERS	Last	4. DATE OF DEATH June 12, 1959	Month June	Day 12	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 26, 1881	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Lewis E. Summers		14. MOTHER'S MAIDEN NAME Clara Taylor						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-6678		17. INFORMANT Mrs. Julia H. Summers (Same as item #1)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO Mycocardial Decomposition				INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Arterosclerotic Cardiovascular Disease				1 year		
(c) DUE TO Parkinson's Disease						2 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____ P.M., from the causes and on the date stated above. ACTUAL SIGNATURE A. T. Brice, M. D.						ADDRESS (Street, city or town, state) Jefferson, Md.		
PHYSICIAN'S NAME (Type) A. T. Brice, M. D.						DATE SIGNED 13 June 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/59		22c. NAME OF CEMETERY OR CEMETORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE C. J. Knob		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06779

6790

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 300 East 3rd Street				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 300 East 3rd Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Strange		First Hall	Middle Talbott	Last	4. DATE OF DEATH June 18, 1959	Month June	Day 18	Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 27, 1882	9. AGE (in years last birthday) 77	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY: U.S.A.				
13. FATHER'S NAME David Wesley Talbott		14. MOTHER'S MAIDEN NAME Corissa Rogers								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. 214-68-5131		17. INFORMANT Mrs. Ora Linger Talbott (Wife)		Address 300 E. 3rd St.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage										
DUE TO Arteriosclerosis										
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis										
DUE TO Arteriosclerosis										
C. (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) None		(County) None	(State) None	
21. I certify that I attended the deceased from May 29, 1957 to June 18, 1959 that I last saw the deceased alive on June 18, 1959 , and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick, Md. DATE SIGNED 6/20/59										
ACTUAL SIGNATURE A. Austin Payne										
PHYSICIAN'S NAME (Type) Dr. A. Austin Payne		M.D. 41 East Church Street, Frederick, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/59		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Gilley Jr.		ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				
VS A15 (4) 15M 9/55		DATE JUN 23 '59								

2. T.

2. next red to 2. 2.

18 2. 2. 00 (511)
18 2. 2. 00 (511)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6791

CERTIFICATE OF DEATH

Reg. Dist. No.

16780

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE								
Frederick MARYLAND		Maryland b. COUNTY Frederick								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
RURAL Frederick	7 days	Frederick								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS								
Frederick Memorial Hospital		102 West 14th Street								
3. NAME OF DECEASED (Type or print)		First	Middle							
David		Michael	Turner							
4. DATE OF DEATH		Month	Day							
		June	3							
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours	12. IF UNDER 24 HRS. Min		
Male		white		MAY 29, 1959	19	0	0	0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Infant				Frederick, Maryland		USA				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
Robert S. Turner, Jr.		Helen Bush								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		None		Mother Mrs. Helen Turner						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4 days								
Tumor		Immatuinity								
DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(Birth Abt 3-4)								
(b)										
DUE TO										
(c)										
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from 29 May, 1959, to 3 June, 1959, that I last saw the deceased alive on 2 June, 1959, and that death occurred at 2:40 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)							DATE SIGNED	
ACTUAL SIGNATURE R. L. Guest		M.D. 6 West Third St.							3 Je 59	
PHYSICIAN'S NAME (Type) Russell L. Guest		Frederick Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-5-59		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JUN 5 '59							24b. REGISTRAR'S SIGNATURE Arthur S. Etchison	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by funeral director.
 page 3 should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1
11
11

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6792 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

16781

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#3	
3. NAME OF DECEASED (Type or print) First LEON Middle JUNIOR		4. DATE OF DEATH Month June Day 22, 1959 Year	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1922	
9. AGE (in years from birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emory Leon Virts		14. MOTHER'S MAIDEN NAME Bertha Cutsail	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 193-18-8676	
17. INFORMANT Mrs. M. Louise Virts—Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart</i> DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Tractor Rolled Over on Chest and Neck</i>			
20c. TIME OF INJURY Hour 3 p.m		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) Farm		20f. (City or town) Frederick-R.F.D.#3, Frederick, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B. O. Thomas</i>		DATE SIGNED 6/24/59	
EXAMINER'S NAME (Type) B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 26, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick Maryland		ADDRESS	
		24a. REC'D BY REGISTRAR DATE JUN 29 '59	
		24b. REGISTRAR'S SIGNATURE <i>C. T. Etchison</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6793

CERTIFICATE OF DEATH

116782

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural— Middletown		c. LENGTH OF STAY IN 1b 8 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley View Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Middletown	
3. NAME OF DECEASED (Type or print) EDNA		First GRACE	Middle WATERS
4. DATE OF DEATH June 11 1959		Last WATERS	Month Day Year
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> October 18, 1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Frederick Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John C. Waters	
14. MOTHER'S MAIDEN NAME Emma Haller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Annie Brandenburg, Middletown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 16 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 1958 to <u>June 11</u> , 1959, that I last saw the deceased alive on <u>June 9</u> , 1959, and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Elmer Harp M.D. Middletown 6-13-59	
ACTUAL SIGNATURE J. Elmer Harp		DATE SIGNED	
PHYSICIAN'S NAME (Type) J. Elmer Harp		Middletown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 14, 1959		22b. DATE THEREOF June 14, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Lutheran
22d. LOCATION (City, town, or county) Middletown, Fred. Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		24a. ADDRESS Myersville, Md.	24b. REC'D BY REGISTRAR DATE JUN 16 '59
3. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6794

CERTIFICATE OF DEATH

06783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		d. STREET ADDRESS 9 Park Ave.,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WILLIS		First I.	Middle WEISHAAR	Last WEISHAAR	4. DATE OF DEATH JUNE 26,	Month JUNE	Day 26	Year 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 7-28-1873	9. AGE (In years last birthday) 85	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Joseph Weishaar		14. MOTHER'S MAIDEN NAME Angeline Reaver						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-10-1259		17. INFORMANT Miss Edna Spurrier, Same		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO BRONCHIAL PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 24 hrs				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) ARTERIOSCLEROTIC HEART DISEASE		DUE TO SEVERE CARCINOMA		6 Month		
		(c) INTESTINAL OBSTRUCTION-METASTATIC				2 WEEKS		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CARCINOMA-METASTATIC-FROM SIGMOID		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from JUNE 17, 1959 to JUNE 26, 1959 , that I last saw the deceased alive on JUNE 26, 1959 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>John M. Culler</i>		ADDRESS (Street, city or town, state) 15 E SECOND ST., JUNE 26, 1959						
PHYSICIAN'S NAME (Type) JOHN M. CULLER		DATE SIGNED JUNE 26, 1959						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-28-1959		22c. NAME OF CEMETERY OR CREMATORIAL Marvin Chapel		22d. LOCATION (City, town, or county) Frederick Co., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE JUN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur & Anna		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for
burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6764 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

416784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roanoke, Virginia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) South Street			d. STREET ADDRESS 2130 Staunton Ave.		
3. NAME OF DECEASED (Type or print) Edward		First G.	Middle Wiseley	Last June 28,	4. DATE OF DEATH Month June Day 28 Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 10, 1918	9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 16 YEARS Months 0 Days 0 Hours 0 Min. 11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pulaski, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charles Walker Wiseley		
14. MOTHER'S MAIDEN NAME Anna Crigger		15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Dr. B.O.Thomas, Sr.		Address 228 N. Market St. Fred. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub Dural Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 900.0					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down flight of stairs at boarding home			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 2 P.M. June 28, 1959		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boarding House 20f. (City or town) Frederick, Frederick, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B.O.Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 29, 1959	
EXAMINER'S NAME (Type) Dr. B. O. Thomas, Sr.		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 6/29/59		22c. NAME OF CEMETERY OR CREMATORIAL Sherwood Cemetery 22d. LOCATION (City, town, or county) Salem, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Chailey Jr.</i>		ADDRESS Frederick, Maryland		24a. REC'D. BY REGISTRAR JUN 30 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116785

6795 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7		c. LENGTH OF STAY IN lb Since 3/56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital				d. STREET ADDRESS 23 West Fifth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GEORGE		First	Middle	Last	4. DATE OF DEATH June 27, 1959	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 17 July 1872	9. AGE (In years from birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brush Maker (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Brush Factory		11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George C. Yinger		14. MOTHER'S MAIDEN NAME Elizabeth Gerlach									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-1714		17. INFORMANT Mrs. Jennie Yinger, 47 E. 5th St., Frederick, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Myocardial infarction Arterio & clausis		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County)	(State)					
21. I certify that I attended the deceased from <u>June 27, 1959</u> to <u>June 27, 1959</u> that I last saw the deceased alive on <u>June 27, 1959</u> and that death occurred at <u>9:35 P.M.</u> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) B. O. Thomas, M. D. 228 N. Market St.	DATE SIGNED 29 June 1959
ACTUAL SIGNATURE B. O. Thomas, M. D.		PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-30-59	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 2 '59		24b. REGISTRAR'S SIGNATURE Orin G. Hause					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

